HEALTH in BERKSHIRE 1966 – 1967

The report of the
COUNTY MEDICAL OFFICER
and
PRINCIPAL SCHOOL MEDICAL OFFICER
for 1966 and 1967

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INTRODUCTION

I am deeply conscious of the long delay in producing this report, resulting initially from several months absence from the office and subsequently by increasing pressures on the department. As previously this combines two annual reports—for 1966 and 1967. One covering 1968 and 1969 will follow closely.

Structure of the National Health Service

In the last report I mentioned criticisms of the tripartite structure of the health service and the difficulties of achieving effective overall planning. Towards the end of 1966 the Minister of Health announced his intention of setting in train an examination of the administrative structure of the health and related services. The "Seebohm" Committee on local authority personal social services was also sitting during the two years under review. These two reports would clearly make a considerable impact on the future.

National Plans

1966 saw the publication of the third in the series of national plans for the development of community health and welfare services. The summaries highlight, even against low national averages, present inadequacies in the provision for the mentally handicapped and in the establishment of mental health and other social workers. The Council's Ten Year Plans would lead to considerable improvements but still leave us below the national average projected for 1975/76. In the field of mental health priority has been given to mentally handicapped children, although plans are being laid for much needed development of facilities for adults. Once our first priority—that of making adequate provision for children—is under way, we shall increasingly have to turn our attention to provision of workshops, training centres and hostels for the adult mentally handicapped.

In the social work field establishment of a post of Principal Social Worker in September, 1965 was a major step in co-ordination of services provided by the Health and Welfare Services Committees, and the establishment of a joint social work service. Tragically, Miss Reidy suffered a serious illness before taking up her appointment, never fully recovered her health, and eventually had to retire on health grounds.

Child Health Clinics

In the last report I referred to a review of the function of child welfare centres and their changing role. 1967 saw the publication of a report of a sub-Committee of the Standing Medical Advisory Committee under the chairmanship of Sir Wilfred Sheldon, which supported many of the suggestions made previously to the Health Committee. The child health service was clearly seen as a continuing necessity, the organisation being undertaken by the medical officer of health: it was equally clearly seen that in the long term the work would be carried out as part of the family health service provided by family doctors working in groups from purpose-built family health centres. Discussions were held with paediatricians and the Local Medical Committee over the recommendations.

Mentally Handicapped Children

In discussing the needs of mentally handicapped children in my last report I mentioned that we were beginning to realise that these children can benefit tremendously from education in its broadest sense. It thus seems more than

logical on this occasion to include reference to the facilities for these children within the chapter on the school health service. The experiment of linking Bennett House School, Abingdon with the Education Committee's Tesdale School for E.S.N. pupils has excited much interest nationally, and the results have more than justified our early hopes. With a policy of recruiting only qualified teachers of mentally handicapped coupled with a trainee teacher scheme and providing opportunities for any existing unqualified teachers to train, together with the adoption of somewhat improved salary scales, the Council is set on a course which should lead to first class provision for these children. We now await the building of adequate accommodation at Bracknell and Newbury and the provision of a fourth school to serve the Maidenhead/Windsor area.

School Health Service

In the last report a section on the school health service was included under the same cover but separate from the remainder. Although this is the responsibility of the Education Committee, provision for the health of the child of school age is an integral part of our efforts to promote health and to prevent illness or to detect it early when it occurs. It is a process beginning in the ante-natal period, continuing into infancy, through the toddler stage, school age, adolescence and into adult life. On this occasion the chapter has therefore been included within the main body of the report. This refers to the review of the service made at the instance of the Education Special Services Sub-Committee. As only too frequently happens it was not possible to implement many of the recommendations because of lack of finance. Whilst the Berkshire education service as a whole stands out well in the national "league table" of expenditure, by contrast, the school health service unfortunately remains low down.

Although the report of the Principal School Dental Officer Mr. Jacob makes no direct reference to this, the Minister of Health has specifically requested information on action taken by the Council on the fluoridation of public water supplies. As this had been rejected, for a second time, by the Council late in 1965 the Health Committee did not see fit to bring another recommendation to the Council during 1966 or 1967.

Nursing Service

Although we were very sorry to lose her we were delighted when our Chief Nursing Officer Miss Lamb obtained a post at the Ministry of Health as Deputy Chief Nursing Officer (Public Health). It is good to know that the country as a whole will now benefit from the progressive ideas which Miss Lamb injected into Berkshire during her term of office. Mrs. Gettings joined us early in 1967.

In her report on the nursing services she refers to the completion of our scheme of attaching nursing staff to general practices—commenced and completed by her predecessor. Although we were just "pipped at the post" by Oxford City, we believe that we were the first County to achieve 100% attachment. Discussions are in hand to extend the principle of cross boundary working with neighbouring authorities, where practices straddle boundaries. Attention is also drawn to the development of schemes for liaison visitors in the paediatric, chest and geriatric fields: those members of staff are "attached" to hospital consultants rather than to G.P.'s.

Health Centres

Progress has been made in developing a programme of health centres. The Didcot project received final approval. The Council also agreed in principle to provide a health centre in Abingdon at the Marcham Road Hospital, as well as to provide clinic accommodation in the town centre area. In Finchampstead we were pleased to join a modest scheme whereby a group practice surgery to be erected by the local doctors will later be linked to a suite of rooms provided by the County Council, thus providing in effect a mini health centre. At Bracknell discussion has continued, but as yet without final agreement on the location of the proposed health centres. There has been a disappointing lack of progress with the replacement of the Maidenhead "Wilderness" clinic.

The Ambulance Service

The chapter on the ambulance service refers to the review carried out by a joint working party. Arising from this Bracknell assumed control of the whole of the county during night hours and at weekends, controls at Didcot and Newbury being operational only on a day time weekday basis. Before these arrangements were put into effect discussions were held with officers of the Reading County Borough ambulance service regarding the possibility of establishing a joint control system, but the proposals were not pursued by the Committee. It was with great reluctance that the Council agreed to begin to phase out the volunteers from the service, although this had become increasingly inevitable both through the inability of the voluntary bodies to provide sufficient volunteers in many areas as well as to the strong views held by the unions.

Family Planning

With the introduction of the Family Planning Act in 1967 the Council decided as a matter of policy to continue to rely on the voluntary agencies for this service: the only directly provided clinic—at Maidenhead—was transferred to the Slough and District Family Planning Association. The Council made arrangements to pay the voluntary clinics for the cost of advice and supplies given to those women seeking help on purely medical grounds, but apart from granting free use of clinic premises where available on other financial support was given.

Health Committee

The Health Committee gave some thought to its structure as a result of which the functions of the Housing Loan Sub-Committee were transferred, more appropriately, to the Finance Committee. The Burnell House Sub-Committee was discontinued and its functions transferred to the Nursing, Maternity and Child Health Sub-Committee. The County Council's representatives on the Area Health Sub-Committees were also asked to explore informally the views of members on the functions of those Sub-Committees.

My thanks are due to the members of the Health Committee and its various sub-committees, as well as of the Education Special Services Sub-Committee for their support during this period and especially to Mr. Arbuthnott who served as chairman of the Health Committee throughout the period under review.

Staff

We were sorry to lose our first Administrative Officer Mr. Parkin who had been responsible amongst other things for a useful re-structuring of our central

administration. We welcomed Mr. John Oakley in his place during 1966.

I should like to conclude by expressing my thanks to the very considerable number of staff, both in the field and central office, who have contributed to the good work during this period, sometimes under most difficult physical circumstances. Thanks are due to those who have contributed to this report and to my Deputy Dr. Hunt who has been responsible for its collation.

D. E. CULLINGTON,

County Medical Officer and
Principal School Medical Officer

AUGUST 1971.

VITAL STATISTICS

POPULATION

The Population continues to rise with an estimated Mid Year population of 460,220 for 1966 and 471,840 for 1967.

BIRTHS

The number of births assigned to the County was 9,163 in 1966 and 9.011 for 1967.

DEATHS

The total number of deaths in 1966 was 4,153 and in 1967 there were 4,149 deaths. The crude death rate per 1,000 population was 9.0 and 8.8 in these years.

SUMMARY

(full details are contained in the tables in the appendices.)

	1966	1967
Population (Mid Year Estimate)	460,220	471,840
Live Births – number	9,163	9,011
– rate per 1,000 Population	19.9	19.1
Illegitimate Live Births (percentage total live births)	5.1	5.6
Still Births – number	122	110
– rate per 1,000 total live and still births	13.1	12.1
Total live and Still Births	9,285	9,121
Infant Deaths (Deaths under one year)	153	126
Infant Mortality Rates		
Total Infant Deaths/1,000 total live births	16.7	13.9
Legitimate infant deaths/1,000 legitimate live births	16.4	15.3
Illegitimate infant deaths/1,000 illegitimate live births	21.3	11.9
Neo-Natal Mortality Rate		
Deaths under 4 weeks/1,000 total live births	11.8	10.6
Early Neo-Natal Mortality Rate		
Deaths under 1 week/1,000 total live births	10.9	9.2
Perinatal Mortality Rate		
Still births and deaths under 1 week/1,000 total live births and still births	23.9	21.1
Maternal Mortality (including Abortion)		
number of deaths	4	2
rate per 1,000 total live and still births	0.4	0.2
Deaths		
Total deaths	4,153	4,149
Death rate per 1,000 population	9.0	8.8

INFECTIOUS DISEASES

The following diseases were notified during the years 1966 and 1967:-

	1966	1967
Dysentery	322	225
Encephalitis (Acute, Infective)	1	–
Encephalitis (Post-infectious)	2	1
Erysipelas	19	9
Food Poisoning	41	60
Malaria	–	1
Measles	3,673	5,963
Meningococcal Infection	1	–
Ophthalmia Neonatorum	–	1
Paratyphoid Fever	1	2
Pneumonia	20	10
Poliomyelitis (Acute, Paralytic)	1	–
Puerperal Pyrexia	8	12
Scarlet Fever	150	118
Tuberculosis (Respiratory)	93	80
Tuberculosis (Non-Respiratory)	12	17
Typhoid Fever	–	1
Whooping Cough	74	262

Full details of the diseases notified are given in tables in the appendices.

Measles continued to be responsible for the majority of the notified cases. Dysentery was the second most commonly notified disease in 1966 when over three quarters of the cases occurred in the Wokingham Rural District. In 1967 one third of the dysentery cases arose in the Wokingham Rural District and there was also a small outbreak in the Borough of Maidenhead.

There was a continuing reduction in the cases of both respiratory and non-respiratory tuberculosis over the two year period. It is interesting to note that there were 80 cases of respiratory tuberculosis notified in 1967 compared with 185 cases only 10 years previously.

Poliomyelitis

For the first time since 1960 poliomyelitis occurred in the county. A girl aged four years suffered from this disease and made good recovery following admission to hospital.

Venereal Diseases

The four main treatment centres for Berkshire residents are situated at the Royal Berkshire Hospital, Reading; the Radcliffe Infirmary, Oxford; the Isolation Hospital, Swindon and King Edward VII Hospital, Windsor. Details of the new cases dianosed and treated at these four centres for the last four years are listed below:-

YEAR	SYPHILIS	GONORRHOEA	OTHER VENEREAL CONDITIONS	TOTAL
1967	11	93	351	455
1966	10	91	350	451
1965	9	71	293	373
1964	8	76	335	419

An analysis of the 1967 figures revealed that 18 of the 93 persons treated for gonorrhoea were under the age of 20 years and three of these were under the age of 16.

IMMUNISATION AND VACCINATION

The arrangements for carrying out immunisation and vaccination have continued as in previous years. The Council's scheme provides for protection against smallpox, poliomyelitis, diphtheria, whooping cough, tetanus and tuberculosis (B.C.G.). Statistics relating to this service are given in Appendix C.

The Health Committee considered an interim report of a trial of measles vaccine, but decided not to introduce it at this stage.

CARE OF INFANTS AND YOUNG CHILDREN

Care of the New-born

Care of the new-born begins with care of the mother in the early ante-natal period. Comprehensive ante-natal care is essential for the child and the mother.

Congenital Malformations

Under the national scheme for the registration of congenital malformations discovered at birth and recorded on the notification of birth form, 119 babes with a total of 159 malformations were notified during 1967. The number of births notified during the year was 9,285, giving a percentage of 1.3 for babies born with a malformation.

During the previous year (1966) there were 117 babes notified with a total of 138 malformations.

The number and classification of the malformations were as follows:-

	1966	1967
Central Nervous System	38	47
Eye, Ear	7	3
Alimentary System	25	34
Uro-Genital System	9	12
Limbs	34	46
Other Skeletal	2	2
Other Systems	13	8
Other Malformations	10	7
TOTAL	138	159

There were no malformations notified under the two diagnostic groups "Heart and Great Vessels" and "Respiratory System."

Infant Mortality

The number of deaths occurring during the first year of life for every 1,000 births has for many years been used as an indication of the effectiveness of maternity and infant health and welfare services. During recent years more attention has been focused on deaths occurring during the neo natal period (the first month of life) and th perinatal period. Perinatal deaths are those occurring before or during labour (stillbirths) and in the first week of life. Prematurity appears to be the cause of over half the stillbirths and approximately 60% of first week deaths, so incidence of prematurity corresponds closely with high perinatal mortality. The following figures show trends nationally and in Berkshire:–

Rates for England and Wales

	1963	1964	1965	1966	1967
Perinatal Mortality	29.3	28.2	26.9	26.3	25.4
Stillbirths	17.2	16.3	15.8	15.3	14.8
Neonatal	14.3	13.8	13.0	12.9	–
Infant Mortality	21.1	19.9	19.0	19.0	18.3

Rates for Berkshire

Perinatal Mortality	26.8	22.2	20.6	23.9	21.1
Stillbirths	16.1	12.8	12.0	13.1	12.0
Neonatal	12.1	10.9	10.2	11.8	10.6
Infant Mortality	18.1	16.0	13.7	16.7	13.9

Small Babies in Need of Special Care

Premature Baby Visitors are available to give the necessary intensive visiting for supervision and care of small babies in their own home. This enables many premature babies to return home earlier, avoiding long separation from their mothers of up to 3 or 4 months. The Premature Baby Visitor works in close co-operation with the General Practitioner. The Consultants at the Special Baby Care Unit are responsible for the general management and supervision of the baby at home.

	1966	1967
No. of cases Visited on Discharge from Hospital	133	137
No. of Visits	1,422	1,375

Care of Infants and Young Children

The Health Visitor advises mothers about infant care. This includes physical and emotional needs. She does this in the home and in Infant Welfare Clinics.

	1966	1967
No. of Home Visits to babies 0-1 year	9,982	10,082
No. of Home Visits to children 1-2 years	10,244	9,856
No. of Home Visits to children 2-5 years	27,154	25,734
Total Visits	47,380	45,672

Attendances at the Council's I.W. Clinics are generally decreasing as more family doctors now prefer to have their own Infant Welfare Clinic at their surgery. The Health Visitor attached to the practice attends the session, so is able to see mothers and babies and can give them advice. This arrangement is popular with mothers, family doctors and nursing staff.

Screening Tests

Each child in Berkshire has a series of health tests to detect conditions that would not otherwise be obvious until later life. This ensures that any necessary treatment can be commenced as soon as possible.

The tests are:-

1. A manipulative test of the hip joint to ensure that there is no congenital dislocation. The test is carried out by medical or nursing staff at birth and at three weeks of age. This test, as a routine for all babies, was commenced on 1st August, 1967, and during the first month two cases were discovered and referred without delay. The diagnosis was confirmed. Treatment, which is comparatively simple for a young baby, was commenced early in both cases. Since that date seven further positive results have been recorded.

2. Phenylketonuria is a disorder of metabolism. If undetected it can result in mental defect due to brain damage. Two routine urine tests are carried out by nursing staff. The first at 2-3 weeks old and the second at 5 weeks old.

3. A simple text for loss of hearing is given to all babies when they are 8 months old. Health Visitors carry out this work after they have received instruction from Mr. Simpson, Headmaster County Audiology Service.

The number of babies with hearing loss that were detected as a result of using this test in 1965 was 24 (for comparison)
in 1966 was 87
in 1967 was 82

All these cases were referred to the specialist for further testing and treatment where necessary.

THE HEALTH OF THE TODDLER

Medical Examination

The toddler needs routine medical examinations, this is being done at Infant Welfare Clinics. Separate toddler sessions to observe development are also of great

benefit to the child and the mother.

A small group of mothers bring their toddlers to the sessions regularly each week over a period of 2-3 months. Play material is provided. During the session the children play together and the mothers observe. A Health Visitor is in attendance at every session. A doctor attends some sessions. The Health Visitor and Doctor spend time discussing individually with each mother development and behaviour problems.

Parents learn a great deal about their children and are given help with practical management of the problems. They also gain a great deal of reassurance, this lessens their anxieties. The toddlers gain experience socially by mixing with other children and sharing toys.

Day Care for Toddlers

At present there is a national and local need for more facilities for day care of the child under five. There are at present 30 regular daily minders in Berkshire, caring for 313 children. The standard of care given is high, and there is a great demand for the services of daily minders. The health visitor advises daily minders and visits them regularly.

NURSERIES AND CHILDMINDERS REGULATION ACT 1948

During recent years there has been a considerable increast in the number of nurseries, playgroups and childminders registered under this Act. Its purpose is to safeguard the health and welfare of the children who attend these establishments or who are cared for by the childminders.

During 1966 there were eight new registrations in respect of childminders and 31 pre-school playgroups were registered. In 1967 there were 17 new childminder registrations and 12 new registrations of nursery schools and playgroups. The position over the last three years can be summarised as follows:-

	1965	1966	1967
Registered childminders in the country	19	18	30
Registered nurseries and pre-school playgroups	42	71	82

At the end of 1967 30 childminders were looking after 313 children whilst there were 1,745 places at the 82 nurseries and playgroups.

SCHOOL HEALTH SERVICE

During 1966 and 1967 the work of the School Health Service has continued, and despite staffing difficulties due to vacancies, maternity and sick leave, it has been possible to cover the bare minimum of the statutory requirements as far as routine medical examinations are concerned.

Children from the age of two years and upwards with suspected handicaps have continued to be assessed and supervised by School Medical Officers, and as far as possible children placed in special schools outside the County have been kept under review.

B.C.G. vaccination against Tuberculosis has been offered to twelve year old children in the County's schools, and in a number of independent schools where this has been requested. Berkshire has continued to participate in the work of the national B.C.G. Control Centre, which has fulfilled a very useful function in evaluating the efficacy of the vaccine. However, the Control Centre ceased to function at the end of 1967 when the Ministry of Health unfortunately withdrew its support and this long and happy association with the Centre and its Director, Dr. Neville Irvine, has ended.

There have been a number of advances during this two year period and these include the rapid expansion of the County's School Audiology Service and the establishment of the post of Senior Speech Therapist. This appointment is proving very successful, not only in the co-ordination of the work of the speech therapy staff, but also because the Senior Speech Therapist is making the Berkshire service more attractive through links with the hospital service, offering facilities for students from the College of Speech Therapists to visit our clinics and by participating in research projects. As in a number of other professions, speech therapists are in short supply, and therefore any measures which make the service more attractive and more efficient, are to be encouraged.

In recent years it has become more and more apparent that a new look should be taken at the aims and structure of the School Health Service.

Since the inception of the service sixty years ago, there have been tremendous advances in the health of the nation as a whole, and in the health services and medical treatment available. During this period the standard of living and nutrition has steadily advanced, leading to improved health in both the child and adult population. Immunisation has virtually eliminated diseases like diphtheria, and more recently poliomyelitis. The incidence of tuberculosis is greatly reduced, and disabilities resulting from this disease are now rare. Meningitis, a serious cause of handicap in the past, is now a treatable disease so that much blindness, deafness and mental handicap due to this cause, no longer occurs.

Since 1948 free medical treatment has been available to everyone through the N.H.S. and not to just a few selected groups. Because of these changes medical treatment is now a negligible part of the work of the School Health Service, and the numbers of certain groups of handicapped children have greatly diminished, but at the same time the child with multiple handicaps, learning difficulties and psychological problems, has come into greater prominence. Nevertheless, the School Health Service has a vital part to play in these days, as an integral part of a wider preventive health service covering the prevention and early detection of defects and handicaps from before conception, into adulthood and old age.

The functions of the School Health Service can be summarised as follows:-

1. Medical examinations, including screening procedures.

2. The findings, examination and supervision of handicapped pupils, and the making of recommendations regarding special schooling to the local Education Authority.

3. Control of infectious diseases.

4. Health Education.

5. An advisory service for parents and teachers, which implies close links with paediatric and other services for children.

6. Research.

Over the past few years it has become evident that although many defects and problems are discovered at the entrants examination at five years of age, at the intermediate stage (ten years) the majority of children are healthy and most defects or problems have already been detected. In addition, with the increasing difficulty in recruiting doctors to the School Health Service, together with an overall shortage of doctors, it has become necessary to make the most economical use of doctors' time. Bearing in mind these factors, in 1959 the Ministry of Education issued regulations authorising local authorities to make alternative arrangements instead of the intermediate examination, and many authorities have now substituted a selective system in its place. Under this method, by means of a parental questionnaire, perusal of medical records, discussion between school doctor, school nurse and teachers, the School Medical Officer is able to select from the age group those children who need help. There is also an opportunity for any child of any age who appears to need examination, to be put forward by the Head Teacher. By this means more time can be devoted to those children who need help. Although certain children are selected for examination, all the children in the age group are given a vision, colour vision and hearing tests.

Medical staffing has become an increasing problem and were it not for part-time women doctors, the School Health Service could not continue. The extended use of general practitioners in the School Health Service has been advocated in some quarters, but there seems no particular merit in this unless the majority of children in the school are their own patients, but this is rarely the case. Furthermore, the School Medical Officer is especially orientated towards health in relation to education. However, in the neighbourhood area of a new town this might be a satisfactory arrangement.

With the changes mentioned in the foregoing paragraphs, the need for a number of more specialised senior medical officers, with training in the field of developmental paediatrics, has emerged. Such doctors would also be closely associated with the paediatric services and take special responsibility in certain fields, for example, audiology or the handicapped pre-school child.

The school nurse plays an important part in the service, in giving support and advice to parents and teachers as well as in the early detection of defects and handicaps. The policy of the Department of Education and Science has always been that school nurses should hold the Health Visitor's Certificate. Since the creation of the Training Council for Health Visitors in 1962, the training syllabus has been altered considerably and more than ever contains much which is irrelevant to the school nurse, yet fails to cover much which is of importance to her. It is evident that the school nursing service is a specialized one, and that consideration should be given to the provision of a specialized course of in-service training. The experiment in Maidenhead where health visitors have undertaken school nursing duties, assisted by a nursing auxiliary, has not shown that a better service can be offered in this way than is offered by nurses working solely in the school health field. The best solution appears to be a specialized school nurse working closely with the health visitors in her area, as this arrangment brings about close links between school, General Practitioner and other services.

In view of all these changes and developments, a review of the School Health Service in Berkshire was carried out during 1967 and a report made to the Education Committee. This report was accepted in its entirety, subject to

financial provision in the estimates where additional expenditure would be incurred. The following were the main recommendations:–

(1) That for the time being routine entrance examinations be retained during the child's first year at school.

(2) That a selective intermediate examination procedure be extended throughout the County and that discussions should take place with the Berkshire Federation of Head Teachers on this proposal.

(3) That the use of the family doctor as a School Medical Officer be arranged for a trial period in the Wildridings area of Bracknell New Town.

(4) That subject to provision being made in the approved estimates for 1968/69, two full time posts be established in addition to the present establishment of Doctors and three of the Medical Officers' posts and re-graded to the post of Senior (Clinical) Medical Officer.

(5) That the County Nursing Officer should assume overall responsibility for the school nursing service and its co-ordination with other County nursing services.

(6) That the appointment of a Senior School Nurse be approved from January 1968.

(7) That the appointment of two additional Nurses be approved subject to provision being made in the approved estimates for 1968/69.

(8) That the experiment of allocating schools to Health Visitors in Maidenhead be discontinued and that the use of School Nurses be resumed in the area.

(9) That attention be drawn to the need to provide adequate accomodation for schools for the medical examination of children.

(10) That consideration be given to amending the bye-laws relating to the employment of children to dispense with the need in all cases for a medical certificate of fitness to take up employment.

Unfortunately, owing to financial restrictions, the implementing of the staff proposals will be seriously curtailed so that there will be no increase in the establishment of Medical Officers, nor will any posts be up-graded. There will not even be an increase to take into account the annual rise in school population. As far as school nursing is concerned, the establishment will be increased by one Nurse only, but on the other hand, the proposals regarding the County Nursing Officer and the appointment of a Senior School Nurse will come into effect in 1968. At the same time the first in-service training course will begin in January of the same year. It may be possible to relieve the staffing position a little by appointing two half-time medical officers working in term time only, in place of some full-time appointments, so that more sessions will be available for school medical examinations. In this way it is hoped that, in spite of financial restrictions, some of the improvements envisaged will be implemented. For example, selective examinations have been tried with success on a limited scale during these two years and it is intended to extend this system throughout the County and at the same time, wherever possible, to arrange for Medical Officers to

visit schools on a termly, instead of yearly, basis so that a closer link is formed between school and Medical Officer.

School Audiology Service

The aims of the service are to detect any degree of hearing impairment, to elicit any obvious cause and where necessary refer, with the family doctor's approval, to a hospital Ear, Nose and Throat department for diagnosis and treatment and the supply of a hearing aid where this is found to be required.

Cases are detected:—

1. From the screening of infants by Health Visitors, when all failures and doubtful responses and those with retarded language development are referred to a School Audiology Clinic.

2. From pure tone audiometric screening of six year old school children.

3. As the result of pure tone audiometry carried out at the request of Medical Officers, General Practitioners, Teachers, Parents, Speech Therapists, Health Visitors and others.

4. As a result of routine audiometric testing of all children who are examined on account of lack of progress at school.

A Medical Officer who has attended a course of training at the Department of Audiology, Manchester University, reads all audiograms in conjunction with any available history. Where the audiogram is outside normal limits there are a number of alternative courses of action. The child may be referred to an E.N.T. Department or to the G.P., but where the hearing loss appears to be of educational significance then the child would be referred to a School Audiology Clinic in the first instance. In other cases audiograms are repeated after a period. Follow-up audiograms are carried out on referred cases at a later date to ensure that following treatment hearing has returned to a satisfactory level and, if not, to ensure maximum educational assistance. Implementation of the audiometric screening of six year olds has been hampered by delays in obtaining a special vehicle for this purpose. However, it is hoped that this will become available during the first half of 1968.

Management and Staffing

Although ascertainment of hearing impairment is primarily a School Health responsibility, because of the educational implications of a hearing loss, however slight, the service is necessarily intimately linked with the Education Department in the person of the Head Teacher of the County's Educational Audiology Service and his staff.

School Audiology Clinics are held weekly during term time at various centres in the County. These are staffed by, a Teacher of the County's Educational Audiology Service, a Medical Officer and a Nurse trained in audiometry. Here a full history and relevant physical examination is carried out together with audiometry, where this is possible, and where necessary parent guidance is given. Children found to have severe hearing losses are supervised educationally by the Head Teacher of the County's Educational Audiology Service and his staff, either in their school or in one of the partially hearing units.

SCHOOL AUDIOLOGY CLINICS

DATE OF CLINICS

	1965			1966			1967		
First attendance : pre-school children	24			87			82		
First attendance : school age children	180			182			196		
Children recalled to Clinic : pre-school	–			13			8		
Children recalled to Clinic : School age	6			19			30		
Total	210			301			316		
Recommendations following attendance at Clinics	Pre-School	School Age	Total	Pre-School	School Age	Total	Pre-School	School Age	Total
Referral to E.N.T. Surgeon	5	81	86	17	85	102	15	79	94
Referral for Psychological Assessment	1	4	5	9	5	14	3	8	11
Nursery/Play-group placement	5	–	5	18	–	18	9	–	9
Speech Therapy	1	7	8	10	11	21	15	9	24
Referral to Family Doctor for removal of wax	–	6	6	–	6	6	1	2	3
Audiometric test after an interval	1	16	17	11	65	76	13	77	90
Appropriate seating at school	–	58	58	–	47	47	–	36	36
No action	3	44	47	13	36	49	14	43	57

Others may be placed in boarding schools for the partially hearing or the deaf. It has been found that in many cases where an audiogram which is outside normal limits has been obtained the child's ears have not been examined by a Medical Officer. In these cases it is not advisable to suggest a direct referral to a Consultant, as the deafness may be due merely to the accumulation of wax or an upper respiratory infection. To meet this problem screening clinics are held periodically which are attended by a Medical Officer and a Nurse trained in audiometry, so that the correct course of action can be determined. Clinics of this sort have been operating since April 1967.

The Nurses who carry out audiometry in the field, at home, in schools, or at other centres, are trained by the Head Teacher of the County's Audiology Service and a Medical Officer. These Officers also conduct a three-day training course for Health Visitors at least twice a year.

Provision

The educational side of the Audiology Service is concerned with provision and operates as one of the County's Educational Services attached to the Special Services Section, and I am grateful to Mr. Simpson, the Head Teacher of the County's Educational Audiology Service, for the following information.

Liaison is maintained with the Medical Services in a variety of ways, viz:-

(i) Through direct contact and correspondence with the School Health Service.

(ii) Through assistance with the training of School Nurses in audiometry and the County's Health Visitors in the screening of pre-school children.

(iii) By attendance at Hospital Audiology Clinics for Berkshire children, where these facilities are available.

(iv) By attendance at the County's Audiology Clinic as a member of the assessment team where decisions are made as to provision in individual cases.

Educational provision is made under the following headings:-

(a) Parent Guidance and the Training of the Pre-school child

This is a specialised branch for experienced teachers who visit the babies and pre-school children in their homes, first to educate the parents in the nature of the disability and how to stimulate language development with the child and, secondly, to carry out direct training. At the same time, parents are helped to come to terms with their problem. Nursery school provision usually follows and visits to the nursery schools in an advisory capacity are made. There is a waiting list for this type of provision and a project to give help and guidance to parents of children under observation has been shelved due to lack of staff.

(b) Special School provision usually arises out of work under Section (a) above. Where the children are very severely affected reports are submitted accordingly and placements thought to be suitable are suggested. Under a three Counties'

scheme, the St. Thomas' School, Basingstoke, provides for the County's severely deaf children, there being no provision in the County itself. During the past two years this school has been unable to meet the need, many children having to go as far away from their homes as the Royal Deaf Schools in Exeter and Birmingham.

(c) Partially Hearing Units

At the end of 1967, three units were in operation:

(1) *The Infant Unit at Emmbrook Primary School, Wokingham*, catering on a full-time basis for eight children. This unit has been constantly full and there is a small waiting list. The unit is to some extent diagnostic and all children spend some time in the parent school, although this has been restricted due to oversized classes there. One child from the unit has been placed in a residential school, and two await similar placements. On the other hand, four children are full time in the ordinary classes and a further child should reach this stage next term.

(2) *Junior Unit, Harwell Primary School.* This unit has been operated successfully on a half-time basis by an experienced teacher without any very special provision of equipment. No children have so far been placed residentially but two backward hearing-impaired children, who originally seemed to come within the category of unsuitable for education at school, have improved to such an extent that they have now been able to take their place in one of the County's schools for the Educationally Sub-Normal, while another child with multiple handicaps has been accepted into the small class of a private school. The roll has been maintained at four but, unfortunately, for various reasons a new location is having to be sought for this unit.

(3) *'The Senior Unit at Emmbrook Secondary School'* is operated on a half-time basis by one member of the staff. This is a successful unit catering for eight pupils and is very secure in the school with which it has grown up. All the partially hearing pupils make their way in the usual classes and visit the specialist teacher for tutorial work in their normal subjects, together with speech and language teaching and remedial work in the basic subjects as appropriate.

(d) *Visiting Work* to children in the ordinary schools is organised under the following headings:

(i) Advisory help to the school staff
(ii) Speech and language improvement
(iii) Auditory training
(iv) Remedial and tutorial work

Children are classified according to need but staffing is so inadequate that only a modest proportion of the children are followed up at all. In the west of the County, from and including the western outskirts of Reading, to the southern and western boundaries, including Newbury, and extending north

to most of the Berkshire Downs, provision has been particularly inadequate and since November, 1967, there has been no provision at all.

The following is an analysis of the commitment as it stood at the end of 1967:-

Peripatetic Case Loads

	Pre School	Infants	Juniors	Seniors	Total	Time Availability
Mr. Carter	–	7	20	32	59	Afternoons daily
Mrs. Simpson	12	11	–	–	23	Afternoons daily
Mr. Simpson	–	–	21	16	37	2 days most weeks
Mrs. Jarrett	8	1	–	–	9	2 Sessions (mornings)
	20	19	41	48		

Total Peripatetic Case Load: 128

Partially Hearing Units

Full Time – Infant Unit	11	:	8 full time infants and 3 juniors in main school
Half Time – Junior Unit	4	:	3 juniors and 1 infant a.m. and p.m. integration
Half Time – Senior Unit	8	:	All integrated—with a tutorial timetable—seen for individual needs

Total Unit and Unit association placements : 23

GRAND TOTAL : 151

Speech Therapy

1966-67 has seen many changes and developments in the Speech Therapy Service.

At the beginning of 1966 there were three full-time and two part-time Speech Therapists. By the end of 1967 the staff had increased to four full-time and three part-time Speech Therapists, including a newly appointed Senior Speech Therapist.

Most of the County areas were fairly adequately served by the Speech Therapy Service apart from the Wallingford, Wantage, Didcot area where, despite numerous advertisements, it was impossible to find a replacement for the Speech Therapist who left in September 1966.

The Senior Speech Therapist was appointed to organise the Service and to liaise with other School Health Services, hospitals and the local education authority.

Regular meetings were organised in the Speech Therapy Service. These were started in an attempt to overcome the feeling of isolation experienced by Therapists working alone in their areas.

One development has been the introduction of Speech Therapy Students from London into the Reading Clinic. Two attend each week and have a small case load of their own, and are supervised by the Speech Therapist in charge. In all areas case loads continued to be heavy with long waiting lists. Regrettably, in many instances, children waited more than six months from the time of referral until the first interview with the Speech Therapist.

One step forward during 1966/67 was the recognition of the fact that more can be done by seeing the child at an earlier age. More pre-school children were seen and the Speech Therapist was able to advise and re-assure the parents.

Although Speech Therapists made more visits to schools for mentally handicapped children, lack of staff prevented an adequate service being developed.

Liaison was maintained with the County Audiology Service and in most cases where the Speech Therapist felt the child to be in need of a hearing test it was quickly arranged. In turn, several children were referred from the School Audiology Clinics to the Speech Therapy Service.

Attendances

A total of 467 children made 7,492 attendances at Clinics during 1966, and 153 new cases were accepted. 126 children were discharged and at the end of 1966, there were 581 children receiving or awaiting treatment.

In 1967 a total of 479 children made 8,918 attendances at Clinics, and 219 new cases were accepted. 193 children were discharged and, at the end of 1967, there were 534 children receiving or awaiting treatment.

Speech Defects

The new cases were classified as follows:-

	1966	1967		1966	1967
Dyslalia	125	152	Indistinct speech	2	4
Alalia	16	1	Cleft Palate	5	3
Stammer	5	18	Combination (more than one defect)	–	23
Language disorder	–	13	Miscellaneous	–	5

School Nursing

The work of the School Nurses has continued to develop and expand in certain fields, and the services which have been available in the past have continued but perhaps a little more on the selective and demand basis rather than the routine.

The new developments include the nurses carrying out the skin test (Heaf) for Tuberculosis and also helping the Doctor with the booster immunizations against Diphtheria, Tetanus, and Poliomyelitis, at the time of the medical inspection.

Audiometric screening tests on six-year old children have been done as much as possible but, owing to the shortage of staff and lack of facilities in some schools, it has been limited.

Certainly the testing of children's hearing has been in great demand. This has served a dual purpose as it has necessitated more visits to schools and parents, thus providing greater opportunity for discussion with Head Teachers about other matters, and liaison with parents.

The work of the School Nurse has been aided by the appointment in 1966 of two auxiliaries and a further one in 1967. They have done valuable work both clerical and out in the field where they have assisted at medical inspections, with hygiene inspections, vision screening and escort duties.

In 1966 a new member of the staff was introduced—dumb, but quite pretty, namely Annie, the model which the nurses use for demonstrating mouth to mouth resuscitation.

The group attachment of Health Visitors to General Practitioners has increased the liaison between the Health Visitor and the School Nurse, the value of which cannot be stressed too strongly.

Three members of the staff have left to become Health Visitors but otherwise, there have been no changes which indicates that the varied work of the School Nurse is interesting and satisfying. This will be further stimulated by the introduction of a series of In-Service Training Courses for School Nurses starting in January 1968.

Handicapped Pupils

During these two years Medical Officers have continued to examine children of two years of age and upwards with handicaps or suspected handicaps. The majority of these examinations involved children not making satisfactory progress at school and although there has been some fluctuation in the yearly numbers, there has on the whole been a slight increase over those shown in the previous year's report.

Ideally, the educationally retarded children should all be been initially by an Educational Psychologist but the present establishment of these Officers is insufficient to make this possible. However, in a certain number of cases during these two years the Educational Psychologist has been able to complete the psychological assessment on the form 2.H.P.

The Educationally Sub-Normal remain the largest group of handicapped pupils, but the Physically Handicapped group is one which has become of special interest in recent years with the development of effective treatment for spina bifida and hydrocephalus. In the country as a whole, about 1,600 children are born each year with this condition and whereas most of them used to die before reaching school age, it is probable that now at least half of them will survive. Generally speaking, in treated children the level of intelligence follows the normal distribution. These children have varying degrees of paralysis of the legs, as well as bowel and urinary troubles, but nevertheless although many require special schooling a large proportion are able to attend ordinary schools. At present cerebral palsied children form the largest group of physically handicapped children but in time, they will be rivalled in numbers by children with spina bifida. It is interesting to note that whereas when West Mead School was first formed as the West Mead Unit, the majority of children attending had cerebral palsy, at the present time only 50% have this condition. The remainder is made up of children with a variety of physical handicaps.

Towards the end of 1966, the Education Committee acquired Hephaistos School for Physically Handicapped Boys which has considerably increased the facilities available for this type of handicap in the County.

By 1968 all E.S.N. Schools in Berkshire will have an assessment class within them. The supervision and assessment of the children in these classes calls for close liaison between School, School Health Service and Psychological Service, as well as contact with other agencies. It has therefore been arranged that once a term the School Medical Officer and Educational Psychologist visit the school to discuss these children and, in addition, these Officers make an additional termly visit to discuss other problems raised by the Head Teacher.

The services for Mentally Handicapped children have continued as before but training school places have been increased by the addition of an extra teacher at both Bracknell and Newbury. The project at Abingdon, where there is a joint Headmaster for both Tesdale School (for E.S.N. children) and Bennett House School (for mentally handicapped children) has continued to be very successful: in 1967 even stronger links were formed by the setting up of a joint Managing Sub-Committee for the two schools.

In all the Berkshire Training Schools a high standard of work has been maintained and at Newbury the 5 day a week hostel has proved very successful. Most of the 14 children in the hostel are there because their homes are too far from a day training school but a few have been placed residentially for social reasons.

The House Parents are to be congratulated on the happy family atmosphere they have created and on the social progress and increased independence the children have achieved.

There seems little doubt that there are some children who would derive greater benefit from 7 days a week boarding in term time and this possibility may need to be considered in the future.

The majority of the Training School teachers are qualifed and it is hoped that before long the remainder will have attended diploma courses. Of the trained teachers most hold a diploma of teachers of the mentally handicapped although at Bennett House School there are a number of Burnham Scale Teachers.

In East Berkshire there is an urgent need for a purpose-built Training School in Bracknell as the present facilities are far from satisfactory. It is hoped that a start will be made on the new school in 1968, and that the building of the Maidenhead School will not be too long delayed for a waiting list is building up and although, up to the present, it has been possible to take children at five years of age this may soon not be the case. Although it is important to admit some mentally handicapped children from two to three years of age upwards, this has not been possible in East Berkshire.

The following are comparative figures relating to handicapped children in Berkshire during 1966/67:

Number of children examined by a School Medical Officer

	1966	1967
Form 2 H.P.	436	472
Form 4 H.P. and other Reports	166	178

	At Special Schools Units or Hostels at the end of		At Home at the end of		Ascertained in	
	1966	1967	1966	1967	1966	1967
Blind	11	11	–	–	1	3
Partially Sighted	13	14	–	1	1	3
Deaf	16	21	1	1	4	7
Partially Hearing	10	14	–	–	7	6
Epileptic	4	7	2	2	1	3
Maladjusted	118	156	15	19	44	43
Speech Defects	2	3	–	–	3	–
Physically Handicapped	69	73	14	16	23	14
Delicate	22	23	19	27	14	13
Educationally Sub-normal	470	594	17	21	261	273

Educationally Subnormal Pupils

	1966	1967
Number of children ascertained as E.S.N.	261	273
Number recommended for special educational treatment at an ordinary school	142	149
Number recommended for education in special schools	119	124

Home Tuition

	1966	1967
Number recommended in	57	47

Mentally Handicapped Children

	1966	1967
Placed in Training Schools	126	147
Placed in Day Hospital	18	13
At home and awaiting suitable placement	80	79
Children in permanent hospital care	97	100
Receiving training at home	5	3
	326	342
On waiting list for Training School *	25	25
Awaiting permanent hospital care	46	38
Admitted for periods of temporary care	27	28
Admitted for permanent hospital care	11	21

*The majority of these children are under 5 years of age.

Enuresis Alarms

Nocturnal enuresis, or bed-wetting, is a very common complaint and in most cases no physical cause can be found for it. Many children become dry by about seven years of age but where enuresis persists and there is no obvious cause, the use of the enuresis bell or buzzer alarm is frequently very effective as the following table shows:–

Enuresis Alarms
issued 1967

Age of child	6	7	8	9	10	11	12	13	14	15	16	Total	Percentage
Successful	3	28	21	19	26	20	8	5	2	4	2	148	74%
Unsuccessful	1	10	6	9	11	7	4	2	1	2	–	53	26%
Total issued	4	38	37	28	3	27	12	7	3	6	2	201	

The alarms are issued by the School Nurse, with the knowledge of the G.P. and each case is followed up at monthly intervals for three months after which the alarm is usually withdrawn. In most cases the children become dry during this period and if not a continued trial is not usually indicated but re-issue after a lapse of a few months is sometimes effective. If a relapse occurs then an alarm is re-issued as soon as possible. At present there are 109 alarms in use and the number on the waiting list is such that there is a 4-6 months' delay before issue.

Immunisation and B.C.G. Vaccination

Booster immunisations continued to be offered to school entrants throughout the period and B.C.G. Vaccination was offered to children of twelve years of age and over in secondary schools and some independent schools.

Employment of school children

During 1966, 1,067 certificates were issued for children in part-time employment and during 1967, this figure was 1,351.

SCHOOL DENTAL SERVICE 1966/67

At the end of December 1967 the staff of Dental Officers was 5 full time dental officers, including the Chief Dental Officer, and 3 part-time officers equivalent to 2.2 full-time officers, also 3 dental auxiliaries full time and the equivalent of 7.4 Dental Surgery Assistants. The past two years have seen a number of staff changes. Mr. Adeline and Mrs. Blake joined the staff as full time dental officers and Mrs. Knox as a part-time officer, and Mrs. Briggs who was full time prior to her marriage is now doing part-time.

We were sorry to lose the services of Mr. Crampton owing to ill health after having been absent for a year. Mrs. Rosenstrauch, Mr. Hewett and Mr. O'Sullivan who were part time dental officers have ceased to be on the staff.

The number of dental auxiliaries is now three, Mrs. Adams having joined the staff in September 1966 to work at the Windsor Dental Clinic.

We have also had numerous changes among the dental surgery assistants. Miss Walters who was I think the third dental surgery assistant to be appointed, retired in September 1966. Miss McNicol who had been on the staff for many years also retired. We welcome their replacements, Mrs. Thornton, Mrs. Hill and Miss Shilling, to the staff.

During the latter part of 1967 we suffered a serious set back with the illness of our dental anaesthetist Dr. Fraser, and we wish him a speedy recovery. It has been very difficult to find anaesthetists to take his place, and this makes one realise how fortunate our service has been to have the same anaesthetist for so many years, and all of us working as a team.

In June 1966 an official visit was paid by Mr. Potter a Dental Officer at the Department of Education and Science. This report was particularly critical of our appointment system, which he believed was responsible for many broken appointments, and he suggested that the clinics should be responsible for making their own appointments, a course on which I preferred to reserve my judgement. With the approval of the Education Special Services sub-committee, a trial scheme was carried out at three clinics allowing the Dental Officer to arrange his own programme of work, and make his own appointments. On assessing the results over a six month period there was some increase in the attendance but not to the degree suggested by Mr. Potter. The Special Services Committee then agreed to our decentralising the running of the service in such other clinics as were suitable. It will take some time to get a true picture of the results, but I am sure they will be much the same as when it was under central control. Another criticism was that in some respects our figures were below the national average. I personally tend to place gaining the confidence of the patient above mere output figures. Young children can be very difficult patients, and I consider that the happy atmosphere we have achieved in our clinics greatly facilitates treatment.

Now that we have Dental Auxiliaries working under the supervision of Dental Officers, Mr. Potter felt some senior posts should be created to form a career structure. This has now been achieved, and two dental officers were promoted to Senior Dental Officers grade at the end of 1967.

It has been a disappointing two years in so much that we have not yet seen a start on the Didcot or Abingdon Clinics. I hope I shall see them become a reality before I retire.

The dental health work carried out by our dental auxiliaries is much appreciated in the areas they have visited, and where it has been carried out over a period of time we are beginning to reap the benefits in cleaner, better kept mouths, and a general awakening of interest in dental health.

I would like to thank all members of the staff, both professional and administrative, for their help and also the staff of the schools for all their co-operation.

Owen Jacob
Chief Dental Officer

SCHOOL PSYCHOLOGICAL SERVICE

The following report for the years 1966/67 has been prepared by Mr. W.C. King M.A., B.Sc., Dip.Psych. A.B.P.S., Senior Educational Psychologist.

During the period under review there have been several changes in personnel. Dr. Singer retired in November 1966 after nearly 18 years of service with the Committee. Dr. Singer made a most valuable contribution to the psychological service and is missed both as a colleague and as an individual. For a

time the service for the County was then undertaken by the remaining two psychologists until February 1967 when Mrs. A. Sands, B.A., was appointed on a part-time basis, working mainly in the East of the County. Mr. K. Were, B.A., was appointed in March 1967, and the working areas of the psychologists could then be re-defined. In September 1967, Miss M. Markham, B.D., B.A., was appointed on a part-time basis, giving us a full establishment of 4 psychologists. Unfortunately, in December 1967, Mrs. Sands resigned to return to Australia.

The change of premises from Caversham to Abbey Mill House has enabled two psychologists to carry out examinations or interviews at the same time and has also enabled us to build up a store of specialist material which all of the psychologists can draw on when required. It has also given us a convenient headquarters for psychologists' official meetings which have been held monthly. The fact that the psychologists can also have a close contact with the School Health Department, the Children's Department and the Speech Therapists in the same building has been invaluable. Unfortunately, lack of car parking space at Abbey Mill House sometimes means that files and bulky test material have to be carried some distance, possibly through the rain, and a brief visit to the building may entail a far longer time spent in parking.

The formal establishment of the Psychological Service and the consequent appreciation of the psychologist's function has led to an increased demand for our services and we see our work as expanding, not only in magnitude but also in kind. Classically the psychologist's work has included such activities as the examination in Child Guidance Clinic, in school, or at home of children who present behavioural or learning difficulties and the subsequent discussion and counselling with parents, teachers or social agency, and the making of recommendations to the Committee. It has also involved the psychological examination of physically or mentally handicapped children with a view to ascertaining suitable educational procedures and it has involved the examination of certain school leavers in conjunction with the Youth Employment Officer. More recently psychologists have been increasingly asked to discuss with teachers the results and implications of educational and relevant psychological research. In addition to this sort of work the psychologists have over the period covered by this report engaged in lectures and seminars with Health Visitors, Health Visitors in training, Trainee Social Workers, Teachers, Nursery Nurses and so on. They were also involved in Mental Health Week and of course have frequently met Parent Teacher Associations. Some of this work has been in the evening but much of it is not so that work in schools may have been curtailed. This is unfortunate, but this teaching is seen as important and we hope may lead to preventive measures in the future. As part of our regular programme we now visit the Special Schools once a month and we try once a term to meet in the school the School Medical Officer, to discuss with the Head and Assistant Teacher individual children. Where Assessment Classes have been established we participate in the process of long term assessment of the children in them.

We have been concerned at the frequency with which we are asked to see children who have already been diagnosed, often by their parents or some person not concerned with education, as "suffering from dyslexia". There is considerable disagreement in the country as to this condition or alleged condition, though the Berkshire psychologists are unanimous in their opinion. There certainly are some children who on test, and in life, appear to be intelligent yet who have undue, perhaps profound difficulty in reading and in spelling, and whatever the point of view with regard to the condition, everybody is agreed that the only "treatment" lies in teaching. This may involve the use of special techniques and it certainly

calls for hard work both by teacher and child. There is no magical solution and certainly the translation of "reading difficulty" into the Greek "dyslexia" does not help in the treatment. There are frequent requests for children described as "dyslexic" to attend special classes in London. It would clearly be more economic both in time and money if these children could be dealt with locally and to this end the establishment of a Remedial Teaching Centre was planned in conjunction with Bulmershe College of Education. The exclusion of this project due to current financial stringency is much regretted. Remedial teaching for intelligent children with learning difficulties is a different project from the special teaching required by children of below average intelligence, but we still see both of these forms of teaching as a major need in the field of education as it impinges upon us as psychologists. We also see a need for day provision for a few children who for psychological reasons are unable to benefit from normal schooling; some of these may be in special boarding schools.

With the cooperation of the Windsor District Medical Officer the psychologist in that area is able to use a room in the Kipling Memorial Building from 4 p.m. to 6 p.m. on Wednesdays when he may be consulted by parents regarding their childrens' problems. This is a new venture and if it proves useful we shall attempt similar schemes elsewhere in the County.

We have devised a referral form for the use of Head Teachers. This enables Heads to give detailed and relevant information about the child referred to the psychologist by means of a "check list". The card was designed with the assistance of the Staff concerned with the computer and certain of the information on it together with the psychologist's results, will be susceptible to subsequent analysis by the computer. Confidentiality will of course be maintained. This should enable us to provide useful statistics, hitherto unobtainable, and may indicate areas of work where we should concentrate or withdraw.

We should like to be able to help in the work with children in Training Schools and there are also other spheres where we think psychologists can help, but it will be clear from this report that the present establishment of four educational psychologists is not sufficient to enable us properly to meet our present commitments.

BERKSHIRE CHILD GUIDANCE SERVICE

The number of new cases referred and total number of children seen for consultation and treatment has reached saturation point over the last two years. Without an all round increase in staff, we are unable to see more children in the time available, and it is even more difficult to undertake regular treatment and provide adequate supervision and follow up of children seen. The number of new referrals has made it necessary to concentrate more on providing a consultation service at the expense of treatment. The traditional method of Child Guidance treatment with regular weekly interviews of child and parent with psychiatrist and psychiatric social worker over a period of a year or more has had to be drastically reduced to a much shorter period of treatment, usually fortnightly interviews for six months or so with a very small rigorously selected number of cases. We need both an increase of staff and alternative methods of treatment to provide an adequate service.

The majority of children referred for Child Guidance examination are seen by the full clinic team, as we find this traditional team approach the best method

of making a thorough assessment of all the factors involved in the child's emotional disturbance. Subsequent supervision may be delegated to other professional workers concerned in helping the child and family, e.g. the family doctor, Child Care Officer, Probation Officer, Health Visitor, School Staff, House Parent. An increase of preventive work has been carried out by discussing early cases of emotional disturbance with Health Visitors. A promising development in the special treatment of maladjusted children is provided by the Day Unit for Maladjusted Children at Brocket, Maidenhead. Similar Units are needed in other areas in Berkshire.

We are glad to hear the Berkshire plans to build a special boarding school for maladjusted children are going ahead. This will extend the facilities for special educational treatment of maladjusted children to those whose home circumstances make residential treatment advisable. At present these children have to be sent to independent special schools, which are often very expensive, far from their homes, and with fewer facilities for psychiatric and psychological supervision and treatment, which will be arranged in a Berkshire school. A local school for Berkshire children will make continuity of treatment possible and facilitate the involvement and treatment of the whole family as part of the child's treatment.

Specially trained teachers can provide a therapeutic environment and special remedial help for the retarded maladjusted child, but there are still a large number of seriously disturbed children and parents, who need individual psychotherapeutic treatment. The appointment of a lay psychotherapist to the clinic team would be most helpful in providing more treatment, and we hope this will be considered in due course. More Psychiatric Social Workers will also be necessary to treat the child's parents and improve the family situation at the same time. The response even to short term intensive work with the family by some of our more mature experienced student social workers has often been dramatic.

Abbey Mill Clinic: Abbey Mill House, Abbey Square, Reading.

The Clinic Headquarters were moved from 27, Kidmore Road, Caversham, to Abbey Mill House, Abbey Square, in February 1966. The central position of the clinic in the town, and the close contact with School Medical and Children's Departments, Speech Therapist and School Dentist in the same building are most helpful. The very limited parking facilities make access difficult for secretarial staff and families attending the clinic. Psychiatric sessions for children at Abbey Mill Clinic are limited to two a week and the provision for follow up and treatment of children seen is very inadequate. More treatment sessions and a Day Unit for treatment of maladjusted children in the Reading area are needed.

Abingdon Child Guidance Clinic: Faringdon Road, Abingdon.

Educational Psychologists. We were very sorry to lose Dr. Singer who retired from the Child Guidance Service in November 1966. Dr. Singer was appointed Clinical Psychologist to the joint Berkshire and Reading Child Guidance Service in December 1948. In the joint clinic Dr. Singer undertook treatment as well as assessment as Educational Psychologist. After the separation of the Berkshire and Reading Child Guidance Service in 1957, Dr. Singer continued as Educational Psychologist to the Berkshire Child Guidance Service and took a particular interest in assessment and treatment of children with specific learning difficulties in language development, reading, writing and spelling. Dr. Singer arranged special

remedial treatment for some of these children under Mrs. Algar at the Abingdon Clinic. This has had to be abandoned since Dr. Singer retired. The Clinic Staff and professional colleagues miss a colleague whose fine clinical judgement, insight and warmth of personality have been a great joy and asset to the clinic team and children seen for assessment and treatment.

We were most grateful for the assistance of Mr. W. Sheridan, Educational Psychologist, now a Lecturer in the Education Department, University of Reading, who filled in as locum Educational Psychologist in the Abingdon Clinic during the Spring Term 1967.

Mr. R. Jeffrey has transfered from Maidenhead to join the team at Abingdon and Reading and Miss M.I. Markham is now working part-time in the Abingdon area.

Psychiatrist: Psychiatric sessions at the Abingdon Clinic were increased from two to four as from September, 1967, by the appointment of Dr. Margaret Myers as locum Consultant Psychiatrist. By the end of 1967, waiting lists, both diagnostic and treatment, had been reduced, as a result of this increase in clinic sessions.

We have been able to start a monthly clinic (one session) at Faringdon from November 1967, this clinic being held under the direction of Dr. Myers.

Clinic Secretary: In August 1967, our devoted and untiring secretary, Mrs. Heather Trenaman, left for family reasons. Mrs. L. Hale has been appointed in her place.

Student Social Workers. The Clinic continues to be used as a placement for students from Psychiatric Social Worker, Child Care and Social Studies Courses. Some of these are already experienced workers and as they come in pairs and occasionally in threes, they form a very effective casework team while they are in the Clinic. Their enthusiasm, indefatiguability, and eagerness to learn transform the Clinic into a busy family casework centre and a conference and discussion centre all at the same time.

Case Conferences: We are now holding conferences after most diagnostic sessions, bringing in all who can contribute to the assessment of the case—teachers, general practitioners, social workers, health visitors. There is room for the development of the Clinic as one of the focal points in the community social services.

Collaboration with Health Visitors. As far as possible we are seeking to involve Health Visitors in cases from the beginning. The Area Nursing Officers are supporting this collaboration, and individual Health Visitors are becoming used to making preliminary visits to the homes of patients referred by doctors and obtaining details of medical and social histories, and also to working subsequently with the families, with frequent reference back to the Psychiatric Social Worker. The Health Visitor is in a position to do some of the necessary social work unobtrusively, and is accepted in some homes where a direct approach from the Clinic would cause a certain amount of alarm and anxiety. The attachment of Health Visitors to family doctors' practices makes them even more useful as a link between General Practitioners and the Clinic.

Newbury Child Guidance Clinic: Greenham House, Newbury.

The Clinic has been held on Mondays with a morning and afternoon session. The morning is devoted mainly to diagnostic (new) cases and the afternoon

mainly to the follow-up and treatment of cases already seen in the diagnostic session. Diagnostic procedure consists of a psychological (intellectual and personality) assessment by the Educational Psychologist and of a medico-psychiatric assessment by the Psychiatrist. The Psychiatric Social Worker, usually having visited the home prior to the initial Clinic interview, discusses the case further with the parents. A case conference follows in which each member of the team contributes his own findings in the presence, when indicated, of other invited professional persons such as Probation Officer, Child Care Officer, etc. A written report with recommendations as to management and treatment is forwarded to the source of referral (G.P., School Psychological Service, Children's Officer, P.S.M.O. etc.) and to other relevant bodies.

Children seen present a variety of problems which can be divided into the following main groups:—

Neurotic states, learning problems (Educational and neurophysiological) conduct disorders and social difficulties.

In the Newbury Area we see rather a high proportion of this latter group—social and financial deprivation, over burdened parents with large families etc. and this does not constitute a group responsive or amenable to psychotherapy but rather to the support of the community and of special social agencies. There is also a rather large proportion of children manifesting learning difficulties such as retardation in reading and writing. These children require remedial teaching help, which is lacking owing to the shortage of available remedial teachers. We feel it imperative to include the E.S.N. child into the Clinic whenever the need arises, to support and advise the parents and to follow-up the child's progress regularly and in close contact with the school.

For part of each year Miss Trafford has had a student under supervision. These students have worked in the Newbury and Reading Clinics and have been a great help, especially as regards home visiting.

Throughout this year the Clinic team has worked under considerable pressure. The volume of referrals is such that the waiting list has become long; some of the less urgent cases already waiting several months have on occasions had to be postponed further so that each urgent case can be seen within a couple of weeks of referral. Because the Clinic functions for only two sessions a week it is thus difficult to provide the amount of treatment and follow-up desired. However, since the commitments of each member of the team outside these sessions are completely full there seems no immediate solution to this problem without increasing numbers of staff.

One of the main administrative problems of the Clinic in 1966/67 has been the constant interruption of clinic procedure by in-coming telephone calls from members of the public requesting appointments or information regarding the Orthopaedic, Eye and Family Planning Clinics. Fortunately this problem has now been adequately met since the secretary of the Newbury Medical Officer of Health has had all these calls directed to herself.

The premises themselves are unsuitable for the work of the Clinic since they are cramped, dingy and materially inadequate but it is understood that there is a likelihood of other more suitable Clinic premises being available in the not too distant future. This will allow the Psychologist and Psychiatric Social Worker,

with a certain re-arrangement of work, to use the Clinic premises on more than one day a week.

We do not propose in this report to quote numbers of children interviewed since this does not really help in assessing the work of the Clinic. But throughout the day interviews and examinations are being carried out almost continuously.

Maidenhead Child Guidance Clinic: Brocket, 15, Boyn Hill Avenue, Maidenhead. During these two years the work of the clinic has been subjected to shortage of staff and frequent changes.

Changes of Staff

Social Workers

1.) Miss Chowdhury left us in November to take up work with the Medical Research Council in Edinburgh. We miss her very much but we are grateful to have had her skill, understanding and clinical acumen with us in Berkshire for a second time. Dare we look forward to her return in the future?

2.) Miss G. Hopkins came to us in August 1966 and remained for a year. In September she went to Edinburgh for the Mental Health Course and we are now looking forward to her return.

3.) Mrs. F. Jacobs came in October 1966. She has been working part-time with the clinic and we hope that she will continue to work with us. She has given excellent help during the clinic's shortage of social workers and deserves our sincere appreciation.

4.) Mrs. B. Sarkar completed the Mental Health Course at the London School of Economics and then worked with the clinic on a temporary basis, remaining for three months.

Psychologists:

5.) Mrs. A. Sands worked with the clinic from mid February 1967 until December 1967. She worked in the Maidenhead area and though she was only with us for a short time before she and her family returned to Australia she did some excellent work and was well liked and is now missed.

6.) Mr. R.J. Jeffery left this area in June to work in Western Berkshire. Having established himself well in this area he has been much missed.

7.) Mr. K. Were took up work in Eastern Berkshire in July 1967. He has opened a consultative centre in Windsor on Wednesday afternoons at Kipling Memorial Buildings with the co-operation of Dr. McClatchey. He is available to Heads of schools, parents or adolescents who approach him direct. The centre is fulfilling a community need.

Clerical Staff

8.) Mrs. P. Mouldey left us in July 1967 because her family moved to

Southampton. She has given ten years of loyalty and help to the clinic and is missed by us all. She was always a very willing and effective help in a crisis.

9.) Mrs. J. Rossington came to us in September 1967. She is settling down well and is becoming an integral part of the clinic.

General inadequacy of the present establishment for clerical staff

When we are limping along without our full complement of clinical staff there is in fact less clerical work than when we have our full complement. Should the happy state of full clinical establishment arise the situation for the clerical staff will be unmanageable again. It is not only difficult to obtain clerical staff but if the staff find conditions are too exacting they will leave.

Change of Clinic Premises

On February 13th 1967 the move took place. Moving house for a clinic of this nature is quite a complicated affair and was effected without a hitch thanks to the excellent co-operation of all the staff concerned including Mr. Ellis, our student at that time.

Change of Character of Clinic

Owing to increase in the volume of work and shortage of clinic staff new methods of treating children are gradually being evolved. We are happy to have the help and co-operation of the school medical officers whose work is proving invaluable.

Brocket Day Unit for Maladjusted Children

Although administratively this Unit comes under the Education Committee it has become an important centre for the treatment of emotional disturbances in young children in the neighbourhood.

NURSING SERVICES

ATTACHMENT OF NURSING STAFF TO MEDICAL PRACTICES

Complete Attachment of all Nursing Staff

Schemes for attachment were completed in 1966. All nursing staff in the County are now attached to family doctors. This is an important development in community care.

Early problems of the scheme were very minor and easily overcome. Attachments are now well established, they are popular with nursing staff and have proved to be successful in every way.

Integration between doctors and nursing staff has resulted in improved communications and gaps in the service are prevented. This has made the work of the nursing team much easier and more effective. Nursing staff and doctors meet regularly to discuss special cases as well as general principles of care.

Cross Boundary Arrangements

Cross boundary schemes with Oxfordshire and Hampshire were introduced in 1967. This means that nurses attached to Berkshire doctors have crossed the County boundary and given a service to patients of Berkshire doctors who are resident in Oxfordshire or Hampshire. Nurses attached to doctors in Oxfordshire and Hampshire who have patients resident in Berkshire have provided the service to those Berkshire residents. The scheme has been a great success and we have not experienced any problems or difficulties. It is hoped that arrangements for similar schemes with other Authorities can be made in future.

The Community Nursing Services

Co-ordination of the nursing services is essential, this has been achieved in Berkshire for some years, and as a result of attachment to family doctors co-ordination has developed and become integrated. The nursing services have become one whole Nursing Service. Staff now work as one team, each team has its specialists for health visiting, midwifery and nursing duties. Wherever possible the team is supported by ancillary help.

The present policy in Berkshire allows for a certain amount of flexibility within the team. This reduces stress on individual members of the team, avoids duplication and prevents gaps in the service. It also makes best use of professional staff time and skills available.

The Health Visitor

During the past twenty years her work has altered, she is now concerned with the whole family and the whole range of medical and social problems. Her duties include:–

(a) *Counselling.* Counselling is used as a problem solving process and of necessity takes a great deal of time. The aim is to enable a person to find their own solution to a problem, by orally expressing their fears and anxieties. Talking about a problem is in itself, a help. The Health Visitor helps to achieve the desired result by being a sympathetic and understanding listener. Ready with reassurance and suggestions.

(b) *Supportive therapy* may be necessary, temporary or permanently where there is a need for a family to lean and be dependent. The aim is to allow the person concerned to share a situation with the Health Visitor. This does not bring a solution to problems but by 'propping-up' an individual or a family during a time of stress or where a problem is insoluble, deterioration is prevented.

(c) *Observing to detect* early signs of physical and mental defects, stresses and early warning signs of potential family breakdown. A little help at the right time can prevent the need for more intensive help and care later.

(d) *Health screening* so that defects which are not obvious can be detected and necessary treatment commenced early.

(e) *Educating* is important as it is the best method of preventing physical and emotional disorder. Health teaching can be practised in large or small groups and to individuals, by; lectures, discussions and advertising methods, to all age groups from the young child of Nursery age to the very old, Health education is an important part of the health visitors work.

(f) *Advising* on health and social problems is necessary, and whenever possible families are encouraged to help themselves.

(g) *Referral* to other agencies and workers, voluntary and statutory when necessary, according to the particular need of the family.

(h) Co-ordinating services given by herself, other social work colleagues, other nursing colleagues, voluntary agencies and statutory services. Ensuring that duplication of work is avoided, that gaps in the service do not occur, and that continuity of care is achieved.

The Health Visitors Work

The Health Visitor has a case load consisting of families who may or may not have any specific problems.

In families where there are not problems, it is important for the Health Visitor to be known to them and to visit them as a routine introductory visit to enable a satisfactory relationship to be made so that when a crisis occurs, the Health Visitor can assess the situation and call on the resources required to aid the family. At present, due to extreme shortage of health visitors resulting in over-large case loads, it is not possible for her to know every family who need her, so she must deal with crises in order of priority.

During her day to day work, the Health Visitor will meet and give help to the following:—

(a) Families where there are medical or social problems and problems of interpersonal relationships such as marital disharmony and adolescent resentment towards parents.

(b) Familiies where there is a stress situation. Stress situations occur when one or more members of a family are affected by a health or social problem causing concern to all members.

This may also occur when there is a temporary loss of one member as in prolonged hospitalisation or permanent loss such as bereavement or divorce.

(c) Families where there are members in special need such as very young or

very old or the handicapped.

When a complex problem occurs in a family and there is an indication for intensive case work, the Health Visitor refers the family to a specialist social worker.

The Health Visitor in the Child Guidance Clinic

During 1967 a scheme was started in Abingdon and Faringdon Child Guidance Clinics for regular case discussions between Health Visitors and the staff of the Child Guidance Clinic. The purpose of the scheme was to establish priorities of need and to ensure that all children with a problem were helped according to their particular need. Mrs. Liddle, Psychiatric Social Worker of the clinic and Miss Galer, Area Nursing Officer, started the scheme which is a great success and has proved valuable to all concerned. Regularly each month Health Visitors meet with the staff of the clinic and bring cases of emotional problems.

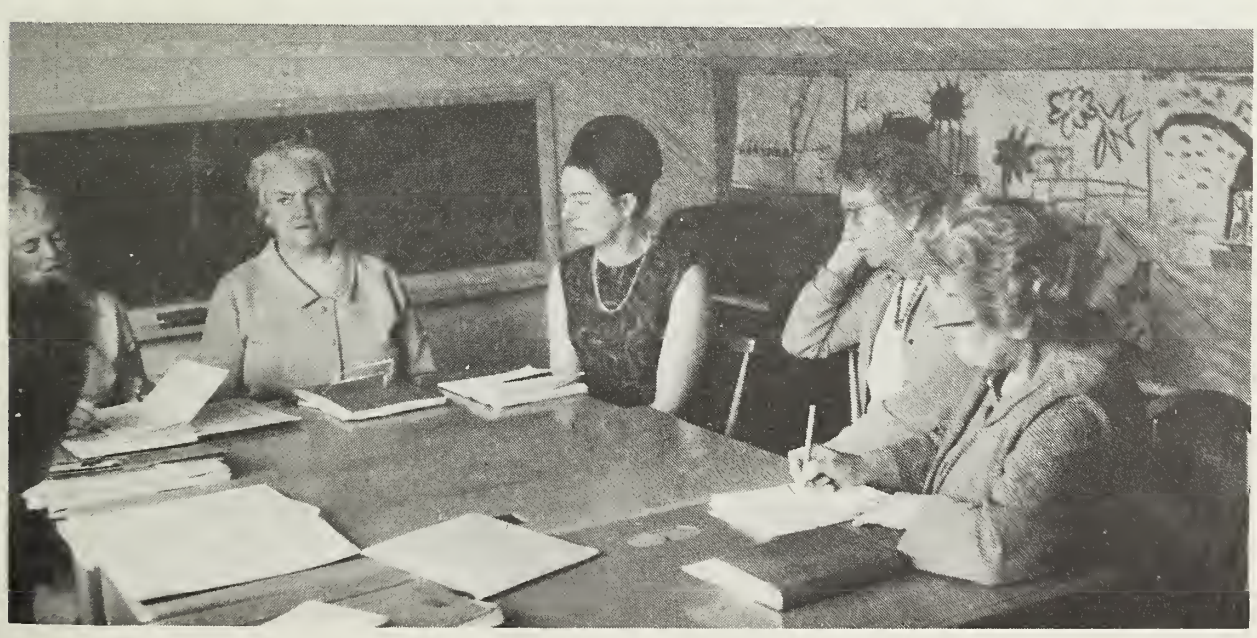
The cases the Health Visitors bring are mostly in the 2-5 year old group. This is the age when emotional problems are usually initially observed. It is hoped that by this early recognition and guidance from the clinic staff deterioration to serious problems can be prevented.

With less severe cases, the Health Visitor retains responsibility and supervises the management. She is advised and guided by the staff at the clinic. With a worrying problem in need of more help than the Health Visitor can give, a clinic appointment is made for the child.

The Health Visitor will advise and encourage parents to bring the child at the appointed time. This personal contact results in attendance at the clinic by parents who may otherwise neglect to keep the appointment.

Follow up of discharged children, by the health visitor, when required, enables the clinic staff to be informed of the child's progress.

The scheme also demonstrates the close co-operation between field workers. Close co-operation is essential to achieve our aims.



Health Visiters and Psychiatric Social Worker meet to discuss cases

Liaison Health Visitors

Specialist Health Visitors are appointed when there is a need for a worker with a knowledge in depth of a particular disorder or condition. In Berkshire we have Liaison Health Visitors who are attached to, and work very closely with, the appropriate Hospital staff. At present we have:–

4 Chest Liaison Visitors
2 Premature baby care visitors
2 Geriatric Liaison Visitors

They are all aware of the services needed to overcome the problems that are associated with the condition. They liaise with all who are concerned in the care of those who are affected. Liaison Visitors also work very closely with the nursing team. It is hoped that a third premature baby care visitor, and a third geriatric Liaison Visitor may soon be appointed so that the whole County will have this service.

Chest Liaison Visitors

Specialist Health Visitors have, in the past, been appointed to work in chest clinics for the purpose of after care and follow up of tuberculosis patients. During recent years the incidence of tuberculosis has fallen, and tuberculosis health visitors have become more concerned with patients suffering from chest conditions other than tuberculosis, notably asthma, bronchitis and lung cancer.

In Berkshire there are four chest liaison visitors who are attached to Consultant Chest Physicians and are the link between hospital, home and family doctor. They are responsible for after-care of patients suffering from all chest conditions.

Chest liaison visitors attend the chest clinic and assist by carrying out various nursing procedures. They are also able to inform the chest physician at the clinic of any relevant factors regarding the patient's domestic circumstances that may affect recovery.

The chest liaison visitor visits patients at home; this enables follow up, and continuity of care to be maintained. She advises patients about various aspects of care and treatment and ensures that necessary treatment is being continued; she may also demonstrate breathing exercises. When necessary she makes enquiries regarding contacts.

Social problems which occur are dealt with by the health visitor or when necessary are referred to a specialist social worker.

The following figures show the numbers of cases visited and the number of visits in 1966 and 1967.

Tuberculosis	1966	1967
Number of cases visited	584	240
Number of visits	2,298	1,047

Non-Tuberculous

Number of cases visited	160	86
Number of visits	515	375

Geriatric Health Visitors

Two geriatric health visitors are attached to Consultant Geriatric Physicians, and they act as a link between hospital staff, family doctors, health visitors and district nurses. Their aim is to ensure continuity of care and follow up of hospital cases. The Geriatric Health Visitor attends hospital clinics for geriatric patients and they see patients in the hospital ward to discuss the arrangements necessary for their discharge. She also visits patients at home prior to admission to hospital to prepare them, and after discharge to ensure that all is well.

The following figures show the work of the geriatric health visitors:—

	1966	1967
No. of cases referred to the Geriatric Health Visitor	942	1,039
Visits by Geriatric Health Visitors:		
Pre-hospital admission	353	315
Post-hospital discharge	1,136	1,192
Patients in hospital	367	328
Other visits		1,696
Total	1,856	3,531

MATERNITY CARE

Preparation for Childbirth

Medical and nursing care are important in the ante natal period, so also is education in preparation for childbirth; this is given to small groups of expectant bothers. Classes are conducted by Health Visitors and Midwives in all areas of the County. Ante-natal mothers attend for a series of eight sessions and are given help and advice about infant care and are taught relaxation. They are also given some knowledge about the physiology of childbirth, this allays their fears and they gain confidence by knowing what will be expected of them during the baby's birth.

Fathers are invited to attend the final session, which is held in the evening. This has been very successful, fathers have an opportunity to ask questions and benefit from the group discussion.

The classes are designed to prepare expectant mothers, so that they can be relieved of tension and anxieties which may be due to fear and/or ignorance. Mothers find this preparation of great help.

An annual study day is held for Health Visitors and midwives, so that they can be informed of new methods in ante-natal teaching.

Confinements

The present aim is for every mother to be able to have her baby in hospital or General Practitioner Unit. Early discharge schemes enable more mothers to be delivered away from home.

The following figures show in percentages the present trend for an increasing number of confinements away from home.

	Total No. confinements	% Hosp. confinements	% G.P. Unit	% Home confinements
1965 (for comparison)	9,393	46.6	28.1	25.3
1966	9,234	50.2	26.8	23.0
1967	9,036	51.0	28.9	20.1

Early Discharge of Maternity Patients

The following figures show an analysis of patients discharged early, according to time of discharge.

	1965 (for comparison)	1966	1967
Within 48 hours	802	719	953
2-7 days	1,366	1,424	1,328
7-10 days	1,180	1,418	1,251
Total	3,348	3,561	3,532
Percentage of early discharges	47.8%	50.1%	48.9%

Domiciliary Midwifery Practice

Midwifery practice is changing. The present trends is for more and more mothers to be delivered in hospital. Many more are being discharged early and nursed at home. The midwife, as a member of the community nursing team, finds that her role too is extended. For example in the field of health education the midwife has a great deal to offer. She is becoming more involved in health teaching, particularly to ante-natal and post-natal mothers.

Midwifery case loads need to be reduced so that midwives have the necessary time to undertake some or all of the following:—

(a) Ante-natal teaching
(b) Participation in Cytology Screening Sessions
(c) Phenistix Screening at one month of age
(d) Screening tests for Congenital Dislocated Hip at birth and 3 weeks
(e) Extended care of the mother and child up to six weeks or more (when there are not social problems and the need is for infant care and feeding problems only).
(f) Advice to mothers about home safety and other aspects of Health Education relating to the midwife's work
(g) Infant Welfare Clinics—In busy sessions where the attendance is high, the midwife may be available to advise mothers of infants up to the age of two months, on feeding and physical care, she refers social problems to the Health Visitor.
(h) Support to the mother under stress during the lying-in period is an essential preventive measure against post puerperal depression.

The midwife is at present responsible for most of these duties, but some, such as (c) (e) and (g) are the responsibility of the Health Visitor, who may delegate them to the midwife.

Hospital Confinement by Domiciliary Midwife

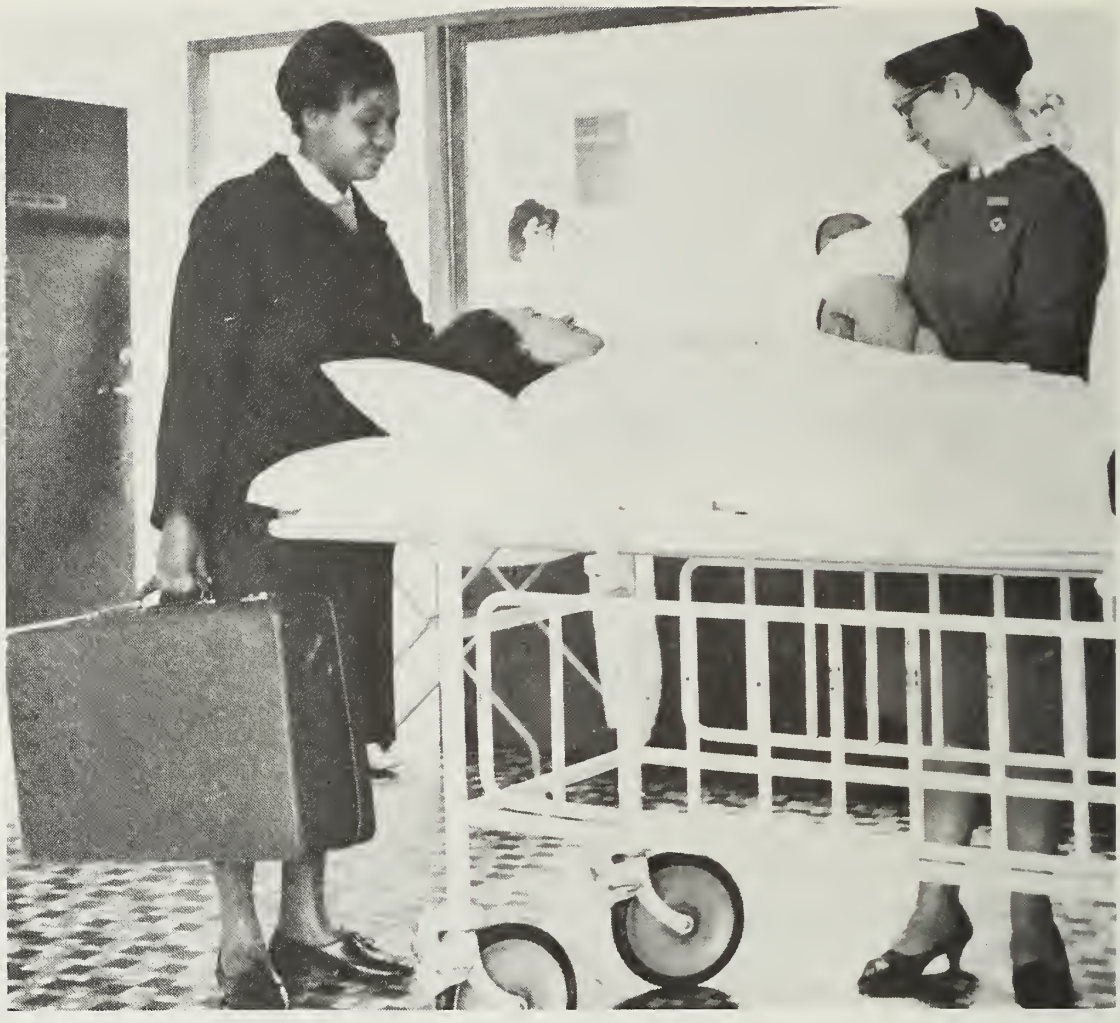
During 1967 a scheme with Wokingham G.P. Unit was commenced. This scheme is for mothers who wished to have their baby away from home, but who were unable to book a bed in Hospital. The domiciliary midwife books the mother and gives her ante natal care. When labour commences the mother is admitted into the Wokingham General Practitioner Unit where the domiciliary midwife delivers her. The domiciliary midwife nurses the mother in the unit and remains responsible for her care. Forty eight hours after delivery the mother is discharged and the domiciliary midwife continues to care for the mother at home. This scheme is successful and popular with both mothers and midwives.

The advantages are:—

(i) It enables more mothers to be confined away from home
(ii) The Domiciliary Midwife is able to deliver a mother to whom she has given ante natal care
(iii) Continuity of care is achieved.

Possible disadvantages:—

(i) Increased mileage for the midwife. This has been negligible, and in some cases mileage is decreased.



Following delivery in the Unit by the domiciliary midwife, mother and baby are taken home at 48 hours.

The Unmarried Mother

The unmarried mother needs extra help in addition to the care and services available to all mothers. The provision of residential care for unmarried mothers is essential. The County Council's own hostel, Burnell House at Windsor, provides accommodation for nineteen expectant or nursing mothers with their babies. During 1966 considerable alterations and improvements were made to the house with some re-furnishing.

Mothers are admitted some weeks before their baby is due to be born and return for six weeks after the baby is born. Weekly classes are held for ante-natal mothers to prepare them for childbirth, in addition a weekly club is held and topics of interest and health education are discussed. The mothers, together with the Sister-in-Charge, choose the subjects for discussion, these cover a wide range of topics.

Other leisure activities are also arranged for those who have particular interests. These include table tennis, games, cookery practice and needlework.

Emotional maladjustment, poor interpersonal relationships, and stresses due to anxiety are often problems of the unmarried mother who is in need of support, kindness, sympathy and understanding. It is our aim to cater for the emotional needs of the mother as well as the physical needs. The staff at Burnell House are all aware of this need and have been successful in achieving a relaxed and happy feeling in the home. This is shown by mothers returning to see the staff after they have left and become happily settled either on their own or with families.

Admissions to Burnell House

	1965 (for comparison)	1966	1967
Ante-natal	78	67	81
Post-natal	15	2	6
Total	93	69	87
Number of Mother included in above figures who were responsibility of other local authorities	39	17	27

(Note: Figures for 1966 low owing to extensive alterations).

Number of Berkshire Mothers admitted to other Homes	7	18	8

Unmarried girls also need skilled case work over a long period. The County Council has an agency arrangement with the Oxford Diocesan Moral Welfare Association, who provide moral welfare workers in Berkshire to give a service of counselling and help.

The following table shows the numbers of Berkshire mothers helped by the Oxford Diocesan Moral Welfare Association and the age distribution.

	Total	14-16 years	17-20 years	Over 21 years
1965 for comparison	332	48 (14.4%)	156 (47.0%)	128 (38.6%)
1966	338	58 (17.1%)	173 (51.2%)	107 (31.7%)
1967	265	34 (12.8%)	127 (47.9%)	104 (39.3%)

The District Nurse

The District Nurse is the Nursing Sister of the team, and is responsible for 'total patient care.'

Total Patient Care includes:–

(a) Basic Nursing
(b) Rehabilitation
(c) Education for the patient's relatives
(d) Support and advice to patient and relatives
(e) Health education when the need or opportunity arises
(f) Prevention of ill health
(g) After care following hospital discharge

Where clinic or surgery premises are available the District Nurse carries out treatment there for any patients who are able to attend. This saves time. She also attends the Cytology Clinics. She may, under the supervision of a Medical Practitioner, give a programme of prophylaxis (with the exception of smallpox vaccination).

Nursing Auxiliaries

During 1966 and 1967 nursing auxiliaries were appointed to relieve the trained staff of work not requiring their skills. The nursing auxiliaries have become part of the nursing team. Most of their work is with the district nurse but occasionally they may be required to assist the health visitor at the infant welfare clinic or the midwife in the ante-natal clinic.

Delegation of nursing duties to nursing auxiliaries is a desirable trend which will no doubt continue.

In-service training is essential for untrained staff and they attend a series of four study afternoons. This course was welcomed by the auxiliaries who are all very keen to learn; they found the lectures and demonstrations most valuable.

Nursing auxiliaries have shown a great enthusiasm for their work and are now necessary members of the nursing teams.

Nursing Care to the Physically Handicapped

Nursing the physically handicapped patient requires a great deal of skill, sympathetic understanding, and time. It is essential to care for the total needs of the patient suffering from such conditions as disseminated sclerosis. paralysis due to poliomyelitis, and muscular dystrophy.

Nursing staff are aware of the important of physiotherapy and rehabilitation and it is essential that nurses have the necessary time to give this care to patients. To enable the nursing staff to carry out this aspect of care, opportunities are made for them to visit physiotherapy departments of hospitals so that they can observe exercises and rehabilitation methods.

Equipment is provided to assist nursing care and to assist the handicapped person to remain independent. The need for equipment continues to increase as the following figures show:—

Aids provided for "After-Care"

Items in Use	At end 1965 for comparison	At end 1966	At end 1967
Various aids to walking	249	407	565
Lifting hoists for the paralysed	14	14	16
Ripple beds for incontinent patients	14	25	26
Special beds	4	—	—
Mattresses	47	39	49
Hospital bed with pole and chain	35	36	48
Separate pole and chain	18	40	42
Bath safety rails	88	145	256
Bath seats	100	158	242
Gadgets for the Arthritic	66	74	92
Sheepskins for the prevention of bed sores	26	32	4
Cantilever bedtables	21	21	21

CARE OF THE ELDERLY

The Needs of the Elderly

Elderly pesons wish to live with dignity and independence in their own home, and it is our aim to help them to do so. The majority can achieve this with little or no help, others may need a great deal of practical help and support. The amount of help an individual person needs, entirely depends on their state of health. Good health is of primary importance to the elderly, so preventing deterioration in the elderly is necessary.

Preventing Deterioration

Maintaining good health among the ageing is possible, it is economically desirable as well as being much more pleasent for the people concerned. Special health clinics where screening procedures and routine medical examinations for the elderly are carried out are practical and successful. It is hoped that we are able to offer such a service in the near future.

The majority of old people regard hearing loss, impaired vision, decreasing mobility, dental defects and various disorders as a normal part of ageing. They do not appreciate that treatment and advice will cure or alleviate. So they fail to consult their doctor and they accept their physical condition as normal.

Because of loss of hearing and vision, communication becomes difficult for them, and with less opportunity to converse and read they receive very little mental stimulus. This reduces their mental ability, which results in apathy and loss of interest. Loss of interest brings further physical deterioration and so a vicious circle once started continues.

Family doctors are aware of the need to maintain the health of their elderly patients, and many have started examining patients as a routine. The nursing staff attached to the practice help by carrying out various pre-diagnostic tests prior to the medical examination. At present, due to large case loads, the district nurses can only give this care to a small number of patients as a home visit to each patient is necessary. Special health clinics would enable many more old people to benefit by having:—

(i) Routine pre-diagnosis tests
(ii) Medical examination
(iii) Referral for treatment when necessary
(iv) Advice on all matters relating to health
(v) Health Education
(vi) Supplementary vitamins and minerals that are essential to correct dietary deficiencies

Activation Sessions

Mobility is essential if an old person is to remain independent. Exercises are necessary to maintain maximum mobility but will only be practised if interest is aroused. Activation is the practice of exercises presented in a way which arouses interest, such as by using a familiar tune and adding words appropriate to the aims or the movements of the exercises. Alternatively, the exercises may be presented as a game for two teams.

Activation sessions are held in the clubs and the homes provided through the Welfare Services Committee. The health visitor or the district nurse lead the activation session. The sessions are successful and are popular with the old people.

The number of activation sessions held in the County during 1966 was 55 and during 1967 was 98.

Health Visitor with a group of older people practising activation

Nursing Care

Many elderly at home require nursing care and/or nursing treatments, this is essential for their comfort and well-being as well as being medically necessary. This work is carried out by the district nurse and a large proportion of her time is spent caring for the elderly. She is concerned with the total needs of the patient, emotional as well as physical. In addition to nursing techniques and procedures she gives the sympathy and support that is as vital to the patient as practical care. She endeavours to meet each individual patient's special needs, and is very much aware of their problems.

The elderly often need prolonged nursing care, this may make them introspective and selfish. District nurses are familiar with this attitude and their

knowledge and experience enables them to manage such patients with ease, by giving them sympathy and showing kindness and compassion.

Comprehensive patient care also includes help for the relatives who may be bewildered and anxious. The district nurse is able to reassure and advise them. She also teaches them how to care for the patient and will explain the patient's condition so that they are better able to understand the patient's needs. This allays the relative's fears and anxieties, and prevents stress, it also gives them confidence when caring for the patient. Relatives need this help and find it extremely valuable, it enables them to manage a situation that otherwise may have become intolerable.

Not all elderly patients need comprehensive care, there are many who need practical care only, such as regular injections or dressings. Some may need assistance with bathing or a bed bath, this basic nursing care may be delegated to the nursing auxiliary who is supervised by the trained district nurse. Some patients cannot be nursed by one person on her own, and for these special cases the trained nurse is assisted by the nursing auxiliary, and occasionally by more trained nurses. An example of this occurred when Mr. X who urgently needed an amputation of his leg refused to be admitted to Hospital. It was essential that he should have the operation, as there was no alternative treatment. Following discussions between the medical staff concerned, it was suggested to him that he be admitted for the operation and discharged home 48 hours later. He agreed to this, so had the operation and was discharged home early. He was successfully nursed at home, which is not the ideal place to give the special care needed following a major operation such as his, but it was his wish to be at home. His complete recovery was gradually achieved without complication, relfecting credit on the team of district nurses who made it possible.

Integrated District Nurse Training Course

A new scheme was commenced in September 1967. Student Nurses from the Royal Berkshire Hospital were seconded to undertake district nurse training in Berkshire. Third Year students were offered this Course as an alternative to the present choice of Obstetric or Psychiatric Nursing Certificate.

At the end of the three months, students take the National Examination for District Nursing. The Certificate is awarded to successful candidates after they have passed the Final Examination for State Registration. This first Course was a tremendous success and the scheme will continue.

Practical Work Instructors

Early in 1967 it became apparent that there was a need for a field Instructor in the home nursing service. Full consideration was given to the problem of providing continuing student supervision to those in training for the National District Nursing Certificate. This supervision needs to be given by experienced district nursing sisters with an aptitude for guiding students. They should also have some preparation for this work. The term "practical work instructor" was used so as not to cause confusion with the Field Work Instructor, who is a Health Visitor.

Initially eleven nurses were selected to act as practical work instructors. They attended a special day release course in August, 1967. In September 1967 students were placed with them for supervised practical work.

The practical work instructor has successfully filled a need. No doubt further practical work instructors Courses will be arranged as the need arises.

Nurses' Uniform

During 1966, twelve nurses and midwives participated in an experimental scheme, wearing plain clothes instead of uniform. All twelve nurses completed a questionaire at the end of the trial period. Their answers indicated that wearing plain clothes had advantages. Patients particularly like the informality of plain clothes. Where they had previously been somewhat overwhelmed by the authoritative aspect of a uniform, they found their relationship with the nurse or midwife was made easier, so improved.

Staff enjoyed the opportunity to wear clothes of a style they liked and with a variable climate, can be more comfortably dressed in all weather conditions.

Protective clothing is a necessity for all nursing duties, and nurses not in uniform are issued with white coats.

All nurses and midwives may choose whether or not they wear uniform and it is interesting to note that the number wearing plain clothes has gradually increased to forty-seven.

HEALTH EDUCATION

Preventing illness and promoting health is a primary objective. Health education is the best method of prevention. Teaching the principles necessary to promote and maintain good health is therefore of utmost importance. All nursing staff, particularly health visitors are involved in health education.

Health education is needed for all age groups from the very young child of nursery age to the very old. It can be given to an individual as well as to groups, large and small.

The methods used vary according to the subject and the age group. As well as lectures, talks, films and discussions, health propaganda is needed so advertising techniques such as displays, leaflets, posters, demonstrations and exhibitions are also used.

Health Education for the Young Child

Health education for the young child must necessarily be done by educating the child's mother. Displays with a special appeal for the pre-school child are arranged in Infant Welfare Clinics. The topics include dental hygiene, road safety and other subjects that affect a child's health and development. Toys, animals and puppets are used to demonstrate the topics. These attract the child's interest, and the mother's attention. While the child is looking at the display the mother becomes aware of the important points. Frequently mothers explain to the child the meaning of the simple message.

Health Education for the School Child

School children of all ages need and are receptive to health education, but choice of subject is important. Health education programmes are given by health visitors to school children of all age groups, at the invitation of the head teacher. The length and content of health education courses are decided by the head

teacher in discussion with the health visitor. This will depend on the particular age group and needs of the individual class. As a basis for discussion the following programmes are suggested:—

1. *Programme suitable for Children aged 5 to 7 years*

Series of ten talks, one each week for one term. Duration of each talk 20 to 30 minutes.

i) General introductory talk including posture
ii) Correct breathing and handkerchief drill
iii) Teeth and dental hygiene
iv) Feet and foot exercises
v) Care of nails and prevention of nail biting
vi) Routine basic hygiene, washing and bathing
vii) Spread of infection by flies etc.
viii) Sleep and rest
ix) Hair washing and brushing
x) Summary of previous talks or additional topical subject.

2. *Programme suitable for eleven year old boys and girls*

One year course in three parts, one lecture each week. Duration of each lecture 35 or 45 minutes.

Part One—10 lectures

Anatomy and physiology and human biology

i) Cells and tissues
ii) Bones and the skeleton system
iii) The skin and sense of touch
iv) Teeth, temporary and permanent
v) The digestive system
vi) The eye and vision
vii) The ear and hearing
viii) The male reproductive system
ix) The female reproductive system
x) Development of the foetus and physiology of normal childbirth.

Part Two—12 lectures

Maintenance of health. Prevention of infection.

i) Personal hygiene
ii) Preventing spread of infections in health and disease
iii) Exercise and rest—it's importance related to development and efficient body functions
iv) Nutrition—effects and defects
v) Prophylaxis
vi) Preventing eye strain and defects of vision
vii) Care of the feet, and prevention of defects
viii) Dental caries, their prevention
ix) Venereal diseases—the dangers, the risks, the problems.

The final three lecture periods are left unplanned to allow for flexibility and will include subjects of topical interest, or of particular interest to the individual groups.

Part Three—9 or more lectures

Parentcraft, Home Safety, First Aid, Social Services.

i) Child development
ii) Physical and emotional needs of the child
iii) Prevention of accidents involving heat and appliances (electric, gas, fire etc.,)
iv) Prevention of accidents involving medicines, poisonous household chemicals and falls
v) First Aid—Introduction and basic principles
vi) First Aid—Burns and scalds
vii) First Aid—Fractures
viii) First Aid—Suffocation and drowning
ix) Social Services in relation to the needs of the school child.

Additional lectures according to needs.

3. *Programme suitable for 14 to 15 year old boys and girls*

Series of lectures, one each week, for two terms. Duration of each talk 40 minutes.

"Design for Living"

Part One—Family relationships

i) The role of parents
ii) Relationships with siblings
iii) Extended family relationships
iv) Extended family relationships continued

Part Two—Social Relationships

v) Individual responses to attitudes
vi) Role play demonstrating lecture No. 5
vii) Community responsibility

Part Three—Leisure

viii) Discussion on the value of planned use of time, to include all aspects of recreation and relaxation.

Part Four—Adolescence

ix) Physical aspects of adolescence
x) Emotional aspects of adolescence
xi) Personal relationships
xii) Aspects in modern society

Health Education for Adults

Health Visitors and nursing staff give lectures regularly to the following adult groups:—

i) Ante natal mothers ("Preparation for Childbirth" previously mentioned)
ii) Mothers Clubs
iii) The Elderly ("Activation" previously mentioned)
iv) Groups of women who attend the Cytology Clinic.

They are also frequently invited to speak at meetings of clubs and organisations, to employees at the request of employers and to parent teacher groups.

The range of subjects given is very wide, and there is an increasing number of requests from the public for talks on cancer, smoking and lung cancer, venereal diseases, and drug dependency. It is good to know that people are interested in these problems and are wanting to know more about the preventive aspects.

The volume of health education work carried out by the nursing staff is very great indeed, as can be seen by the following figures:

Health Education Sessions

Type of Session	1966	1967
"Preparation for Childbirth"	1,809	1,635
Mothers Clubs	296	288
Other Adult Groups	189	229
Teaching in Schools	898	855
"Activation"	55	98
Total	3,247	3,105

(Figures for health education in the Cytology Clinics are not included as the teaching is informal and secondary to the main purpose of the clinic.)

The reduction in sessions for "Preparation for Childbirth" does not reflect a decline, it occurs as a result of re-organisation. During 1967, in some areas, two sessions were combined into one for economic reasons.

Teaching Aids

Health Education lectures are illustrated by using various aids such as:

i) Films
ii) Film strips
iii) Film slides and photographs
iv) Flannelgraphs
v) Flip charts
vi) Teaching charts and graphs
vii) Any equipment, or every-day object appropriate to the subject.

There is need for more variety and improvement in the health education

aids available, it is not always possible to buy or hire the required equipment. So nursing staff necessarily must make their own. This is not ideal because it takes a great deal of time, and the end product, though good, might be better if designed by a professional artist and manufactured commercially.

CERVICAL CYTOLOGY

Cytology clinics are held in all areas of the County. At this clinic, women over the age of thirty-five attend and have a simple test taken. This test shows whether or not a woman will develop cancer of the cervix.

It is recommended that this test be repeated every five years. Those attending also have a thorough medical examination as well as the test.

The following table shows the increase in clinics, sessions and attendances since this service was introduced.

	Clinics	Sessions	Attendances	
1965 (for comparison)	1	15	180	(Wantage only)
1966	5	68	1,183	(new clinics started at Wallingford, Newbury, Faringdon and Wokingham during 1966)
1967	8	150	2,161	(new clinics started at Bracknell, Maidenhead and Windsor during 1967)

The number of positive results in 1967 was eleven. All patients were subsequently treated and it is good to know that this simple test has prevented the occurrence of a serious condition that would have caused great suffering to the patients and a great deal of unhappiness to their relatives.

HOME HELP SERVICE

The need for the Home Help Service continues to increase, this service plays a major role in caring for the family in the home.

The work of the home help is flexible and duties vary according to particular need in individual cases. The duties include cleaning the home, cooking, shopping and help with laundry. In-service training is necessary for home helps, talks and discussions have been arranged in all areas, they were well attended and proved to be a success.

At the end of 1967, eleven Home Help Supervisors were in post. By maintaining a high standard of work, by improving recruitment, and avoiding delay in getting help to those in need, the Home Help Supervisors have played an important part in the service. The Health Visitor remains responsible for financial assessment and for determining priority of needs.

The elderly at home are particularly helped by the home help service and account for approximately 77% of all cases. The service enables old people to be cared for at home. Without such a service many of the elderly would be unable to stay at home.

Home Helps are also essential for the long term care of the physically handicapped in their own homes.

The number of maternity cases requiring home help, though not large, has increased during 1966 and 1967.

Number of Cases assisted by Home Help Service

	1965 for comparison	1966	1967
Aged 65 and over	1,807 (77.9%)	2,008 (76%)	2,243 (77.3%)
Chronic & T.B.	149	167	152
Mentally disordered	18	10	8
Maternity	166	182	214
Other	179	242	218
Total	2,319	2,609	2,898

MENTAL HEALTH SERVICE

Adult Training Centres and Workshops for Mentally Handicapped

The three premises in Maidenhead, Windsor and Newbury continued to function in the dual role of adult training centre and workshop. They operate to meet the needs of the mentally handicapped adults and the staff at these centres endeavour:—

(a) To give social training in order that the trainees will be able to live and work in the community with the minimum assistance.
(b) To offer realistic work training in order to enable the trainees to find work in open employment in the future.
(c) To provide work at various levels for the trainees in attendance.

A. *Maidenhead*

This centre now has a maximum capacity of 45 trainees and there were 43 on the roll at the end of 1967 and a staff consisting of one manager and three instructors. The centre is situated at "High Close". North Road, Castle Hill.

B. *Windsor*

As is the case in Maidenhead, the centre operates in rented premises, at the Congregational Church Hall, Victoria Street. There is a maximum capacity of 35 although the centre has never been full and only 26 were on the roll at the end of 1967. The staff consists of a manager and two instructors.

C. *Newbury*

This centre now functions in the grounds of Donnington Lodge in the outbuilding known as "Red Lodge". There is only room for 18 trainees and every place was filled during 1967. The Headmistress of the Newbury training school continues to fill the post of part-time manager and she is assisted by a male and a female instructor. For the present this centre only operates during "school hours" and is closed during school holidays.

D. *Trainees*

The trainees attending the three centres generally fall into one of the following groups:—

(1) Young persons who have previously attended a junior training school or an E.S.N. school who require further social and educational training to meet the needs of adult life. Such persons usually stay in the centre for a few months then move into open employment.
(2) Older persons whose education has been completed but who require sheltered working conditions and some attention to their social needs.
(3) Persons who are grossly handicapped, mentally and physically, who are not able to undertake many types of work processes but require some form of occupational therapy.

At the present time about two thirds of the trainees fall into the second group, one seventh in group one and the remainder in group three.

Future Needs

A centre is urgently needed in the Abingdon area to meet the needs of the adult mentally handicapped in North Berkshire whilst a new large workshop is required as soon as possible in Newbury to replace the existing centre at Donnington Lodge. A new centre is also required at Bracknell whilst one large purpose built centre will soon be required in the Maidenhead/Windsor area to replace the temporary centres in these two towns.

With these centres there will be the need to recruit trained instructors and it will also be necessary to arrange to second some of the existing instructors on to training courses leading to appropriate qualifications for their work.

Home Teaching

There were five Home Teachers on the staff in 1967 who were able to spend half their time with mentally disordered persons and the remainder of their time with physically handicapped people.

In connection with their mental health duties, these teachers who are also occupational therapists, made visits to all the mentally subnormal and severely subnormal children and adults in the county who were not able to attend a training school, adult training centre or workshop and were not able to obtain employment in the community.

It was usual to visit a person at least once a week for a period of training extending over one hour. In addition, training was given to small groups of these persons in one of their homes or in temporary premises. Other visits were made to

the workshops where assistance was given in various aspects of occupational therapy, social training and social assessment.

Mrs. Hope, Home Teacher in North Berkshire comments:—

"In January, 1966, Miss Cooper and I started a group for older mentally handicapped girls which is held every Thursday in Trinity Methodist Church Hall, Abingdon.

The group is aimed at providing social integration, social education and an opportunity of learning to work together. The activities include preparation and cooking of simple meals, self care incorporating hairdressing, make-up, etc., monetary values, time telling, shopping, use of telephone, recognition of public notices etc. We also do physical training, dancing, craftwork and group work such as label making, addressing and folding circulars. Due to a playgroup run in the hall at the same time quite a lot of outside interest has been taken in these girls and several tea parties in private homes took place which were highly successful."

South Field Hostel

This hostel was opened in July, 1965, adjacent to Field House Hostel in Wokingham. The hostel was designed to meet the needs of adolescent girls showing signs of "maladjustment" who had previously attended Field House (an Education Committee establishment) and had attained school leaving age.

The two hostels operate under the joint direction of the same warden and the Health and Education Committees set up a Joint House Committee to look after both hostels. By operating a flexible admission policy it has been possible to arrange for a girl receiving full-time education to be transferred to South Field if she was sufficiently mature and, conversely, an immature girl leaving school at 15 could be retained in Field House.

During 1966 a total of eight girls were admitted to South Field and nine were admitted during 1967. There was an average of seven girls in occupation throughout that year. It has always been the aim of the hostel staff to produce an environment in which girls may grow towards emotional maturity and Mr. Cochran, the Joint Warden made the following observations at the end of the first year:—

"It is, perhaps, true to state that we are all still in the process of getting to know and accept each other. Weekly staff meetings are proving to be extremely helpful. At these meetings the progress and treatment of each individual girl is discussed. Time is also allowed for general conversation between members of staff. The Matron of South Field spends one whole evening each week at Field House. This not only allows her to get to know and form relationships with girls before their transfer to South Field, but also enables her to experience the environment in which the girls have lived prior to their arrival at South Field.

It was fortunate for new members of staff that the initial group of girls admitted to South Field formed a reasonably well integrated group, displaying only mildly disturbed behaviour patterns. The later admission of a girl displaying a delinquent behaviour pattern has already created problems. Possible future admissions will result in a sharp division of the group into sub-groups and all the pressures and tensions inherent in such a situation. This is, of course, what one

anticipates to be the normal situation in a hostel such as this—the initial group was 'abnormal' in its make-up. The fact that there will be a slow build-up in the number of girls resident at the hostel, and not a mass admission, is of extreme importance. This will enable better foundation work—essential in any major project, but especially so when the project is breaking new ground in the national field. The strength of the foundations will affect not only the present girls but also all future girls."

A considerable amount of support and help has been given to the girls and the hostel staff by Dr. Doniger, the Psychiatrist in the East Berkshire Child Guidance Service. Dr. Doniger and the other members of the child guidance team play an important role and Mr. Cochran adds:—

"Continuous support is given by the child guidance team. Dr. Doniger visits Field House every week, girls at South Field receiving the same attention as those at Field House. So as to prevent girls having to miss school or work, and to prevent the embarrassment suffered by the girls in such situations, Dr. Doniger has visited South Field during the evening, taking a leading role in group discussion (by virtue of her presence), and then being available for individual sessions with the girls.

Psychiatric Social Workers keep hostel staff closely in touch with the girls' home situations, and their work as ever proves invaluable in the fostering of better parent/child and parent/hostel staff relationships.

After-care is being undertaken by both the child guidance clinic and the hostel staff. It is accepted that, in certain circumstances, after-care may well result in the re-admission of girls to the hostel."

Social Clubs

Voluntary organisations and voluntary workers operated six social clubs in the county for mentally disordered adults. Three of the clubs were designed to meet the needs of the mentally ill whilst the other three cater for the mentally subnormal.

Mental Health Statistics

Nine hundred and eleven adults were referred to the local Health Authority during 1967. The great majority (841) were mentally ill and the remainder came under the categories:—

Psychopathic 26; subnormal 34; severely subnormal 10.

At the end of the year there were 807 adults under supervision as follows:—

Mental Illness	202
Elderly mentally infirm	47
Psycopathic	14
Subnormal	276
Severely subnormal	268

One hundred and four of these persons were attending workshops/training centres, 14 were attending day hospitals, 32 were receiving home training and 635 were receiving home supervision. Twenty two were residing in homes or hostels at local authority expense.

Fifteen adults were on the waiting list for admission to hospital at the end of 1967 and six of these persons were in need of urgent admission.

Further statistical information is contained in the appendices.

CHIROPODY SERVICE

As in previous years there was no provision for a chiropody service provided by the authority and once again grants were made to voluntary organisations which provided a service for aged and disabled persons. During the early part of 1966 the annual grants were based on a sum of 4s. 0d. for each treatment carried out but this sum was raised to 4s. 9d. in April, 1966. Thus the grant had almost doubled within a three year period (2s. 6d. a treatment at the beginning of 1964).

14,184 treatments were given at 69 centres in the county during 1966. In 1967 the number of treatments again increased to 17,896 and there were then 68 centres in operation.

It is interesting to note the growth of the service over the last four years:—

	1964	1965	1966	1967
Number of Centres	41	44	69	68
Number of treatments given	10,210	13,000	14,184	17,896

Nevertheless there are still areas of the county where there is no service available and many of the existing centres are still not able to meet the demands made upon them. The extension of the service is limited to some extent by lack of suitable clinic premises, shortage of qualified chiropodists and limitation of financial resources. Needless to say the provision of a domiciliary service is still not possible whilst financial restrictions continue to operate.

AMBULANCE SERVICE

Once again there has been an increase in the number of patients carried by the ambulance service and the mileage undertaken by the vehicles. During 1967, 103, 322 patients were carried by ambulance vehicles and 794,529 were conveyed by the hospital car service. The combined mileage undertaken by all the vehicles was over one million six hundred thousand miles. On the other hand the average ambulance mileage per patient fell to 7.7 the lowest level for many years. This was the result of introducing more efficient measures in order to ensure that full and better use was made of vehicles.

The vast majority of the patients were taken to hospital and out-patient clinics or other out-patient departments and it is this group of patients who are responsible for the continued increasing demand on the service. The number of accident, emergency and maternity cases taken to hospital has varied very little over recent years. Full details of the ambulance statistics are contained in the tables in the appendices and these tables contain statistical information relating to the years from 1963-1967 in order that the increased volume of work that has occurred over the last five years can be appreciated.

Review of the Ambulance Service

The review of the ambulance service, carried out by a working party of officers of the Health Department and an officer of the Joint O & M Unit, was completed during 1965. Matters discussed in this report were considered by the Ambulance Sub-Committee and the Health Committee and the following principal recommendations were accepted by the Council in 1966.

Standard of Service

The Council continue to maintain a service under which no part of the county is more than 10 miles from a station having a stretcher case vehicle capable of being mobilised with a trained crew of two men at any time of the day or night.

Location of Stations

With one exception, the existing number and location of stations are considered adequate to serve the needs of the county.

Control System

Subject to there being a satisfactory solution to the technical problems involved, Bracknell Control should be operational for 24 hours each day and the Didcot and Newbury Control should be operational only during normal working hours.

Staffing

The staff to be consulted on a long term solution to stand-by duty and overtime difficulties, having in mind the principles that all stand-by duties at stations should be abolished, stand-by duties at home should be curtailed and the staffing requirements at stations should be assessed on the basis of a 40 hour week plus reasonable overtime.

Volunteers

Volunteers should be encouraged to continue to provide the services existing at present. If volunteers cannot provide a service at any of the existing stations they should be permanently replaced by full-time staff.

Staff Training

The principle of staff training to be approved.

Consultative Committee

Approval in principle given to the establishment of a joint consultative committee for manual workers of the ambulance service.

Other recommendations accepted related to an improved supervisory structure on improved uniform issue and close liaison and co-operation with neighbouring ambulance authorities.

Revised radio arrangements were necessary before Bracknell Control could

communicate with ambulances all over the county and it had not been possible to put this system into operation by the end of 1967. Similarly difficulties concerning the constitution of the Joint Consultative Committee prevented this recommendation from being put into operation.

It was possible to make improvements to the supervisory structure and a Divisonal Ambulance Officer was appointed to the East Berks Division in May, 1966. New posts of Leading Ambulance Drivers were created at all the sub-stations and main stations and improved gradings were obtained for the Control Clerks at the three controls.

Stations

The ambulance building programme for the year 1966/67 consisted of the erection of ambulance stations at Windsor, Didcot and Bracknell. Owing to financial restrictions and difficulty in obtaining loan sanction (Windsor and Didcot) and delay in obtaining a suitable site (Bracknell) no new stations were built during 1966 and 1967. A move was made into temporary premises at Windsor (the old fire station) in March, 1966. These premises proved to be far more satisfactory than the previous premises in Trinity Square.

Extensions were made to Newbury Station during 1966, providing garage space for additional vehicles. It was necessary to find alternative accommodation for the full-time crew at Hungerford during 1967 as the premises at the Hungerford Hospital were required to provide accommodation for hospital patients. Fortunately temporary accommodation was made available in the St. John Ambulance Brigade hut.

With the introduction of 24 hour manning at the main stations the need for central heating at Newbury, Maidenhead and Bracknell became apparent and it is anticipated that a suitable form of heating will be made available at these stations in the future, particularly for the vehicle bays.

Staffing

At the end of 1967 the full time staff employed at the six ambulance stations, four sub-stations and the Bracknell Ambulance Control consisted of:—

One Divisonal Ambulance Officer
Two Station Officer/Controllers and four Station Officers
Two Deputy Station Officers and eight Leading Ambulance Drivers
Seventy five Ambulance Driver/Attendants
One Senior Ambulance Control Officer, one Senior Control Clerk and eight Control Clerks

It was as a result of the ambulance review proposals that a Divisional Ambulance Officer was appointed to the East Berks Division (May, 1966). During that year leading drivers were also appointed at the five main stations and three sub-stations. At Abingdon the leading ambulance driver was promoted to station officer. It was also necessary to appoint two additional driver/attendants at Maidenhead Station in November, 1966 to replace the volunteers.

During 1966 the part time ambulance control clerk post at Newbury was changed into a full time post and two additional control clerks were appointed at the Bracknell Control in April, 1967 to meet the demands of the extra work at that control centre.

The introduction of a 40 hour week in January, 1966, the development of shift working at the main stations and the introduction of a paid lunch break resulted in an increase in the number of hours worked by the existing staff and also a significant increase in staffing costs.

Vehicles

There were 43 vehicles in use at the end of 1967 and these consisted of 22 stretcher vehicles, 16 dual purpose vehicles and five ambulance cars. Five Princess ambulances were purchased (one an additional vehicle and four to replace existing vehicles) and it is of interest to note that this type of vehicle provided an exceedingly comfortable ride for the patient.

Employment of Volunteers

In February, 1966 the Council accepted the recommendations of the Health Committee that:—

(1) Volunteers should be encouraged to continue to provide the service existing at present.
(2) If volunteers cannot provide a service at any of the existing stations they should be permanently replaced by full time staff.

During the following months discussions took place with representatives of the Union to which the majority of the full time ambulance personnel belong. These representatives pointed out that the policy of the Union was to oppose the use of volunteers at all times except in time of emergency, firstly because of the effect their use had on negotiations for better pay and conditions, and secondly because the Union believed that volunteers could not provide as efficient a service as full time men.

As a result of these discussions the Council resolved, on 16th July, 1966, that:—

(a) A phased transition to a service fully manned by ambulance employees should only take place if and when the report of the Government Working Party (Part One; Ambulance Training and Equipment) is accepted so as to make use of voluntary staff unacceptable.
(b) No objection be raised to negotiations being opened with the Unions representing the ambulance staff before the report of the Government Working Party is accepted.

As a result of the ensuing meetings it was finally agreed towards the end of 1967 that the use of volunteers at the Abingdon Ambulance Station be terminated on 1st April, 1968 and that the use of volunteers in the county be completely abolished by 31st March, 1970.

During the time these discussions were taking place it is interesting to note that volunteers at Maidenhead, and Windsor found that they could not provide an adequate service throughout the year and they were eventually replaced by full time men at both these stations.

The part played by the volunteers in the ambulance service in the past has

been considerable and the general public in Berkshire owe them a debt of gratitude.

Staff Training

The principle of staff training in the county was approved in February, 1966 but during the two years covered by this report it has not been possible to appoint additional personnel in order to enable training to be carried out during working hours. Attempts were made during these two years to provide in-service training at a number of stations and these generally had to be held at the week-ends. The training sessions were not entirely satisfactory owing to the small number of personnel who were able to attend. At the same time the instruction was dependent on the goodwill of a limited number of individuals who offered their services during their free time in order that some form of training could be provided.

In order to ensure that regular in-service training can be introduced in the future it is essential that additional ambulance driver/attendants are appointed (at least 6 per cent increase on the present establishment). Similarly, personnel newly appointed to the service would be able to be seconded to one of the six week residential training courses provided by a neighbouring authority if there is provision for additional staff and the appropriate finance to meet the cost of the training course.

Sudden Illness in the Home

In October, 1966, at the request of the Minister, consideration was given to the handling of cases of sudden illness in the home and the relevant instructions were issued to control staff. It was decided that the appropriate instructions laid down in AMB. FORM 28 were entirely satisfactory and read as follows:–

Requests for Ambulances from Private Addresses

Members of the public can make a request for an ambulance in respect of an accident or sudden illness in a public place (including a school), a maternity case or an accident wherever it might occur (including a private house).

An ambulance should *not* be provided in response to a call in respect of sudden illness in a private house. Instead the caller should be advised that a doctor should be consulted and an ambulance would only be provided at the request of the doctor. At the same time the ambulance control should give the caller any help possible to get a doctor to the patient, and it is permissible to give the caller telephone numbers of doctors in the area. If necessary the control should make every effort to contact any doctor available to deal with the emergency.

Ambulance Competitions

The annual County Ambulance Competition was held at Bracknell in April, 1967 and six teams took part. The winners of this county competition, Mr. and Mrs. Forward of Windsor, represented Berkshire in the Regional Ambulance Competition organised by the National Association of Ambulance Officers. This competition was held at Bournemouth during the same month and the Berkshire team was placed third.

Later in the year a member of the Ambulance Committee presented a cup to be held for a period of 12 months by the most efficient ambulance station in

the county. Following an inspection of all the stations the cup was awarded to Maidenhead Station.

OTHER SERVICES

Recuperative Holidays

Convalescence of a recuperative type can be provided for persons not requiring medical or nursing care.

In 1966 a total of 16 persons were admitted to 14 holiday homes and their average stay was two weeks. During 1967 it was found possible to provide 14 persons with a recuperative holiday and the average length of stay was again two weeks.

Registration of Nursing Homes

There were no new registrations in 1966 and at the end of the year 13 homes were on the register, providing a total of 323 beds.

During 1967 there were three new registrations and one cancellation. At the end of that year there were 15 homes on the register providing 332 beds.

Routine inspections of all these homes were undertaken by medical officers from the Health Department.

Mental Nursing Homes

There were two registered nursing homes in the county providing a total of 23 beds for mentally disordered persons and regular inspections were undertaken during 1966 and 1967.

Residential Homes for the Mentally Disordered

Four homes were operating in 1966 providing places for 112 persons. During 1967 one of these homes was closed and at the end of that year there were three homes with places for 96 persons. As in the case of the mental nursing homes these premises were inspected throughout the two years by a medical officer.

Medical Examination of Staff

The medical questionnaire system was introduced in April, 1965 and it continued to operate during 1966 and 1967.

Six hundred and seventy questionnaires were passed to the department for scrutiny by a medical officer in 1966. Of these 640 were recommended for admission to the Council's superannuation scheme whilst the remaining 30 persons were required to undergo a full medical examination before any recommendation could be made. During 1967, 615 completed questionnaires were received and it was found necessary to refer 35 persons for medical examination.

After the medical examination of these 65 persons it was considered that:—

Four persons were medically unfit for admission to the superannuation scheme.

Recommendations in respect of the other 61 persons were as follows:—

13 persons	Category A.1.	Fit for admission
38 persons	Category A.2.	Fit for admission
7 persons	Category B.1.	In good health at the time of the examination but suffering from permanent defects likely to shorten the full term of active service.
3 persons	Category B.2.	In good health but suffering from permanent defects likely to interfere to some extent with efficiency though not serious enough to make the candidate unfit.

The continuation of this scheme has resulted in a considerable reduction in the number of medical examinations that would otherwise have been undertaken by the medical staff. Under the present system 615 medical examinations have been carried out in 1967 and this shows the increase in the number of persons entering the Council's employment during recent years when comparison is made with 1964, the year before the new scheme was introduced. During that year only 271 persons were medically examined.

Medical Examination of Teachers and Student Teachers

	1966	1967
Students entering Training Colleges	390	476
Students leaving Training Colleges	76	264
Teachers taking up their first appointment	90	88
Teachers and students examined for other local authorities	45	26
Total	601	854

Road Traffic Act

In 1966, 35 cases were referred for an opinion in respect of fitness to hold a current driving licence. Of this number it was considered that 11 persons were medically unfit to hold a licence to drive a motor vehicle.

During 1967 there were 59 cases referred for opinion and it was considered that 13 persons were medically unfit to hold a driving licence.

With regard to the 24 persons who were medically unfit it is interesting to note that 17 were suffering from epilepsy, three were suffering from a mental illness, one had defective vision whilst the remaining three people were receiving treatment for a cardio-vascular disorder, a neurological disorder and a chronic respiratory infection respectively.

APPENDIX A

(as at 31st December, 1967)

HEALTH COMMITTEE

Chairman: A. Arbuthnott, Esq., M.B.E., E.D.,

AMBULANCE SUB-COMMITTEE

Chairman: J.G. Price, Esq., T.D.,

NURSING, MATERNITY AND CHILD HEALTH SUB-COMMITTEE

Chairman: Miss R.W. Ruth Whitehead

MENTAL WELFARE SUB-COMMITTEE

Chairman: The Hon. Geoffrey Somerset

HEALTH GENERAL PURPOSES SUB-COMMITTEE

Chairman: Major H. Fairfax Harvey, M.B.E., M.C.

EDUCATION COMMITTEE

Chairman: Mrs. B.E. Scott

EDUCATION SPECIAL SERVICES SUB-COMMITTEE

Chairman: Mrs. M.E. South

APPENDIX B

STAFF OF THE HEALTH DEPARTMENT

County Medical Officer of Health and Principal School Medical Officer
D.E. CULLINGTON, M.A., M.B. B.CHIR., D.P.H., D.C.H.

Deputy County Medical Officer of Health and Deputy Principal School Medical Officer
F.T. HUNT, M.B., B.S., M.R.C.S., L.R.C.P., D.P.H., D.I.H.

Senior Medical Officer
P.H. CIMA, M.B., B.S., M.R.C.S., L.R.C.P.

Chief Dental Officer
O. JACOB, L.D.S., R.C.S.

Senior Dental Officers
MRS. A.E. BRIGGS, L.D.S. R. LOVEWELL, L.D.S., R.C.S.

County Nursing Officer
MRS. B. GETTINGS, S.R.N., S.C.M., H.V. Cert.

Deputy County Nursing Officer
MISS M.E. LINDARS, S.R.N., S.C.M., H.V. Cert., Q.N.S.

County Ambulance Officer
L.C.J. HARLOW, F.I.A.O., F.I.C.A.P.

Principal Social Worker
MISS A. REIDY, B.A. (ADMIN.), A.M.I.A.

Senior Speech Therapist
MISS A.R. SELF, L.C.S.T.

Administrative Officer
J.G. OAKLEY.

CHILD GUIDANCE SERVICE

PSYCHIATRISTS
DR. C.R. DONIGER, M.B., B.S., D.P.H., D.C.H., D.P.M. (Part-Time)
DR. N. MORETON-GORE, M.D., L.A.H., D.P.M. (Part-Time)
DR. M. MYERS, M.R.C.S., L.R.C.P., N.A.M.H. D.C.P. (Part-Time)
DR. M.E. WARD, M.B., B.S., D.P.M. (Part-Time)

SENIOR EDUCATIONAL PSYCHOLOGIST
W.C. KING, M.A., B.Sc., Dip. ED. PSYCH., A.B.P.S.

SENIOR PSYCHIATRIC SOCIAL WORKER
MRS. D. LIDDLE, A.A.P.S.W.

(as at 31st December 1967)

APPENDIX C

STATISTICAL TABLES

TABLE 1 IMMUNISATION AND VACCINATION FIGURES

	COMPLETED PRIMARY COURSES			RE-INFORCING COURSES		
	1965	1966	1967	1965	1966	1967
SMALLPOX	6,950	6,467	7,451	1,026	2,106	2,543
DIPHTHERIA	7,725	8,671	9,085	12,691	13,624	16,201
WHOOPING COUGH	7,487	8,376	8,447	6,812	7,002	8,399
TETANUS	7,557	8,659	9,085	12,630	13,599	16,201
POLIOMYELITIS	9,341	8,492	13,518	5,626	6,115	12,446

TABLE 2A—NOTIFICATIONS OF INFECTIOUS DISEASES, 1966

DISEASES NOTIFIED	CASES NOTIFIED IN URBAN DISTRICTS								CASES NOTIFIED IN RURAL DISTRICTS											
	Abingdon Borough	Maidenhead Borough	Newbury Borough	New Windsor Borough	Wallingford Borough	Wantage Urban	Wokingham Borough	Total Urban Districts	Abingdon	Bradfield	Cookham	Easthampstead	Faringdon	Hungerford	Newbury	Wallingford	Wantage	Windsor	Wokingham	Total Rural Districts	Total County
Diphtheria	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Dysentery	–	27	–	–	–	8	3	38	2	6	6	53	1	1	16	–	17	1	181	284	322
Encephalitis, acute (infective)	–	–	–	–	–	–	–	–	1	–	–	–	–	–	–	–	–	–	–	1	1
Encephalitis, acute (post-infectious)	–	1	–	–	–	–	–	1	–	–	–	1	–	–	–	–	–	–	–	1	2
Erysipelas	4	1	–	–	–	1	–	6	1	2	1	5	–	2	–	–	–	–	2	13	19
Food poisoning	–	4	1	–	–	3	–	8	–	–	1	7	2	–	–	1	4	10	8	33	41
Malaria	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Measles	23	570	221	283	33	54	284	1468	156	101	147	789	42	127	272	45	139	22	365	2205	3673
Meningococcal infection	–	–	–	–	–	–	–	–	–	–	–	–	–	1	–	–	–	–	–	1	1
Ophthalmia neonatorum	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Paratyphoid fever	–	–	–	–	–	–	–	–	–	–	–	1	–	–	–	–	–	–	–	1	1
Pneumonia, acute (primary or influenzal)	5	1	–	–	–	–	1	7	3	2	1	1	–	4	1	–	1	–	–	13	20
Poliomyelitis, acute (paralytic)	–	–	–	–	–	–	–	–	–	1	–	–	–	–	–	–	–	–	–	1	1
Poliomyelitis, acute (non-paralytic)	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Puerperal pyrexia	–	1	1	–	1	–	2	5	–	–	–	1	–	–	–	–	–	–	2	3	8
Scarlet fever	13	6	6	8	–	1	15	49	9	6	18	22	2	2	6	3	4	6	23	101	150
Smallpox	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Tuberculosis, respiratory	9	12	2	3	1	1	5	33	11	6	4	5	6	1	2	7	3	–	15	60	93
Tuberculosis, meninges and central nervous system	–	–	1	–	–	–	–	1	–	–	–	–	–	–	–	–	–	–	–	–	1
Tuberculosis, other forms	–	2	–	–	–	–	–	2	–	–	–	3	–	–	1	1	3	–	1	9	11
Typhoid fever	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Whooping cough	–	1	4	1	26	–	3	35	7	3	2	25	1	–	2	15	–	4	15	74	109

TABLE 2B–NOTIFICATIONS OF INFECTIOUS DISEASES, 1967

DISEASES NOTIFIED	CASES NOTIFIED IN URBAN DISTRICTS								CASES NOTIFIED IN RURAL DISTRICTS											
	Abingdon Borough	Maidenhead Borough	Newbury Borough	New Windsor Borough	Wallingford Borough	Wantage Urban	Wokingham Borough	Total Urban Districts	Abingdon	Bradfield	Cookham	Easthampstead	Faringdon	Hungerford	Newbury	Wallingford	Wantage	Windsor	Wokingham	Total Rural Districts	Total County
Diphtheria	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Dysentery	5	47	–	–	6	–	7	65	5	14	9	5	6	1	–	41	1	3	75	160	225
Encephalitis, acute (infective)	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Encephalitis, acute (post-infectious)	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	1	1	1
Erysipelas	–	2	–	–	–	–	2	4	–	1	–	2	–	2	–	–	–	–	–	5	9
Food poisoning	–	11	–	3	4	–	1	19	–	7	4	4	4	–	–	1	1	2	18	41	60
Malaria	–	–	–	–	–	–	–	–	–	–	–	1	–	–	–	–	–	–	–	1	1
Measles	350	240	89	254	40	36	97	1106	520	969	168	985	72	284	252	72	176	275	1084	4857	5963
Meningococcal infection	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Ophthalmia neonatorum	–	–	–	–	–	1	–	1	–	–	–	–	–	–	–	–	–	–	–	–	1
Paratyphoid fever	–	–	–	–	–	–	–	–	–	–	–	1	–	–	–	–	–	–	1	2	2
Pneumonia, acute (primary or influenzal)	1	–	–	–	–	–	1	2	3	3	–	–	–	–	–	–	–	–	2	8	10
Poliomyelitis, acute (paralytic)	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Poliomyelitis, acute (non-paralytic)	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Puerperal pyrexia	1	1	–	–	1	1	2	6	–	1	–	–	–	–	–	–	–	3	2	6	12
Scarlet fever	4	2	3	16	–	2	3	30	8	8	7	25	2	2	3	2	4	3	24	88	118
Smallpox	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Tuberculosis, respiratory	3	8	5	4	–	2	2	24	7	4	1	5	2	3	8	7	4	2	13	56	80
Tuberculosis, meninges and central nervous system	–	–	–	–	–	–	1	1	–	–	–	–	–	–	–	–	–	–	–	–	1
Tuberculosis, other forms	1	1	–	–	–	1	–	3	–	1	1	3	–	–	–	2	–	–	6	13	16
Typhoid fever	–	–	–	–	–	–	–	–	–	–	1	–	–	–	–	–	–	–	–	1	1
Whooping cough	–	35	4	8	2	–	3	52	15	23	3	67	–	–	8	1	4	9	80	210	262

TABLE 3A–CAUSES OF, AND AGES AT , DEATH, 1966

Causes of Death in County, 1966	Net Deaths in Age Groups of "Residents". whether occurring within or without the County											
	Age Groups											
	All Ages	Under 4 weeks	4 weeks under 1 year	1 –	5–	15 –	25 –	35 –	45 –	55 –	65 –	75 and over
Tuberculosis, respiratory	12	–	–	–	–	–	1	1	1	1	2	6
Tuberculosis, other	–	–	–	–	–	–	–	–	–	–	–	–
Syphilitic disease	5	–	–	–	–	–	–	–	–	2	1	2
Diphtheria	–	–	–	–	–	–	–	–	–	–	–	–
Whooping Cough	–	–	–	–	–	–	–	–	–	–	–	–
Meningococcal infections	–	–	–	–	–	–	–	–	–	–	–	–
Acute poliomyelitis	–	–	–	–	–	–	–	–	–	–	–	–
Measles	2	–	–	2	–	–	–	–	–	–	–	–
Other infective and parasitic diseases	7	–	–	–	–	2	–	–	1	1	–	3
Malignant neoplasm, stomach	72	–	–	–	–	–	–	1	7	17	22	25
Malignant neoplasm, lung, bronchus	207	–	–	–	–	–	2	5	24	63	71	42
Malignant neoplasm, breast	86	–	–	–	–	–	2	7	18	28	18	13
Malignant neoplasm, uterus	22	–	–	–	–	–	–	1	3	9	4	5
Other malignant and lymphatic neoplasms	419	–	–	5	6	2	7	14	43	84	116	142
Leukaemia, aleukaemia	27	–	–	–	2	3	–	2	1	4	7	8
Diabetes	40	–	–	–	–	–	1	2	4	6	13	14
Vascular lesions of nervous system	578	–	2	–	–	–	1	3	19	56	153	344
Coronary disease, angina	747	–	–	–	–	–	2	18	46	125	240	316
Hypertension with heart disease	41	–	–	–	–	–	–	–	–	8	11	22
Other heart disease	461	–	–	–	–	–	1	5	14	27	82	332
Other circulatory disease	183	–	–	–	–	–	–	5	7	29	36	106
Influenza	36	–	–	–	–	–	1	1	–	5	6	23
Pneumonia	291	2	15	1	2	–	–	1	6	17	55	192
Bronchitis	171	1	2	–	–	1	–	2	5	26	58	76
Other diseases of respiratory system	31	–	–	1	1	–	–	–	–	5	10	14
Ulcer of stomach and duodenum	26	–	–	–	–	–	–	2	–	4	7	13
Gastritis, enteritis and diarrhoea	20	–	–	1	–	1	–	1	2	1	6	8
Nephritis and nephrosis	19	–	–	–	–	1	2	1	2	5	3	5
Hyperplasia of prostate	11	–	–	–	–	–	–	–	–	–	3	8
Pregnancy, childbirth, abortion	4	–	–	–	–	2	–	2	–	–	–	–
Congenital malformations	55	22	16	3	1	–	2	2	3	2	1	3
Other defined and ill-defined diseases	364	81	5	3	6	5	7	10	15	31	49	152
Motor vehicle accidents	87	–	–	2	4	27	10	7	14	7	4	12
All other accidents	91	2	5	4	7	4	2	5	6	7	11	38
Suicide	37	–	–	–	–	3	3	11	8	5	6	1
Homicide and operations of war	1	–	–	–	–	1	–	–	–	–	–	–
All causes	4153	108	45	22	29	52	44	109	249	575	995	1925

TABLE 3B—CAUSES OF, AND AGES AT, DEATH, 1967

Causes of Death in County, 1966	Net Deaths in Age Groups of "Residents". whether occurring within or without the County											
	Age Groups											
	All Ages	Under 4 weeks	4 weeks under 1 year	1 –	5–	15 –	25 –	35 –	45 –	55 –	65 –	75 and over
Tuberculosis, respiratory	5	–	–	–	–	–	–	–	2	3	–	–
Tuberculosis, other	1	–	–	–	–	–	–	1	–	–	–	–
Syphilitic disease	6	–	–	–	–	–	–	–	1	1	3	1
Diphtheria	–	–	–	–	–	–	–	–	–	–	–	–
Whooping Cough	–	–	–	–	–	–	–	–	–	–	–	–
Meningococcal infections	1	–	–	1	–	–	–	–	–	–	–	–
Acute poliomyelitis	–	–	–	–	–	–	–	–	–	–	–	–
Measles	1	–	–	1	–	–	–	–	–	–	–	–
Other infective and parasitic diseases	9	–	2	–	–	–	–	–	1	1	3	2
Malignant neoplasm, stomach	94	–	–	–	–	–	–	2	9	15	32	36
Malignant neoplasm, lung, bronchus	204	–	–	–	–	–	–	2	27	64	69	42
Malignant neoplasm, breast	78	–	–	–	–	–	3	3	19	19	19	15
Malignant neoplasm, uterus	25	–	–	–	–	–	–	2	9	3	4	7
Other malignant and lymphatic neoplasms	447	–	–	7	3	3	10	15	46	94	106	163
Leukaemia, aleukaemia	27	–	1	–	2	1	3	1	2	2	10	5
Diabetes	31	–	–	–	1	–	–	–	–	6	5	19
Vascular lesions of nervous system	608	–	–	–	–	1	5	8	15	60	129	390
Coronary disease, angina	792	–	–	–	–	–	2	15	54	149	244	328
Hypertension with heart disease	37	–	–	–	–	–	–	–	–	3	10	24
Other heart disease	427	–	–	1	–	–	2	4	9	26	74	311
Other circulatory disease	185	–	–	–	–	–	–	2	8	26	31	118
Influenza	1	–	–	–	–	–	–	–	–	–	1	–
Pneumonia	289	4	4	–	1	2	5	4	3	17	37	212
Bronchitis	159	–	–	1	–	1	–	–	6	23	48	80
Other diseases of respiratory system	33	–	1	–	3	–	–	2	3	4	11	9
Ulcer of stomach and duodenum	23	–	–	–	–	–	1	–	–	3	6	13
Gastritis, enteritis and diarrhoea	28	–	2	3	–	–	2	–	–	3	5	13
Nephritis and nephrosis	19	–	–	–	1	–	–	2	2	6	5	3
Hyperplasia of prostate	9	–	–	–	–	–	–	–	–	1	1	7
Pregnancy, childbirth, abortion	2	–	–	–	–	1	1	–	–	–	–	–
Congenital malformations	44	24	10	4	2	1	2	1	–	–	–	–
Other defined and ill-defined diseases	362	65	4	5	8	9	6	12	15	40	48	150
Motor vehicle accidents	74	–	–	3	3	21	6	8	12	6	5	10
All other accidents	85	3	6	6	4	6	4	3	5	3	11	34
Suicide	55	–	–	–	–	3	5	6	7	6	5	3
Homicide and operations of war	8	–	–	–	2	2	1	3	–	–	–	–
All causes	4149	96	30	32	30	51	58	96	225	584	922	1995

TABLE 4A–PATIENTS UNDER L.H.A. CARE (31st DECEMBER, 1966)

Category Age	Mentally Ill		Psycopath		Subnormal		Severely Subnormal		Total		Grand Total
	Under 16	16+	Under 16	16+	Under 16	16+	Under 16	16+	Under 16	16+	
Attending day training centre	–	1	–	–	–	16	121	80	121	97	218
Awaiting entry thereto	–	–	–	–	–	2	25	9	25	11	36
Attending day centres at hospitals	–	–	–	–	–	1	18	11	18	12	30
Receiving home training	–	–	–	–	–	5	5	28	5	33	38
Awaiting home training	–	–	–	–	–	–	–	–	–	–	
Resident in L.A. home-hostel	–	5	–	–	–	4	10	3	10	12	22
Awaiting residence thereto	–	–	–	–	–	–	–	–	–	–	
Resident at L.A. expense In other homes-hostels	–	4	–	–	–	1	1	3	1	8	9
Receiving home visits (not including above)	1	157	1	15	–	251	49	92	51	515	566
Total number	1	167	1	15	–	280	229	226	231	688	919

TABLE 4B—PATIENTS UNDER L.H.A. CARE (31st DECEMBER, 1967)

Category Age	Mentally Ill		Psycopath		Subnormal		Severely Subnormal		Total		Grand Total
	Under 16	16+	Under 16	16+	Under 16	16+	Under 16	16+	Under 16	16+	
Attending day training centre	–	–	–	–	–	15	139	89	139	104	243
Awaiting entry thereto	–	–	–	–	–	–	25	–	25	–	25
Attending day centres at hospitals	–	–	–	–	–	1	13	13	13	14	27
Receiving home training	–	–	–	–	–	6	3	26	3	32	35
Awaiting home training	–	–	–	–	–	–	–	–	–	–	–
Resident in L.A. home-hostel	–	3	–	–	–	5	14	3	14	11	25
Awaiting residence thereto	–	–	–	–	–	–	2	–	2	–	2
Resident at L.A. expense In other homes-hostels	–	7	–	–	–	1	1	3	1	11	12
Receiving home visits (not including above)	–	192	–	14	–	248	43	134	43	588	631
Total number	–	202	–	14	–	276	240	268	240	760	1000

TABLE 4C—PATIENTS AWAITING ADMISSION TO HOSPITAL (31st DECEMBER, 1966)

PATIENTS ADMITTED FOR TEMPORARY RESIDENTIAL CARE DURING 1966

Category / Age	Mentally Ill		Psycopath		Subnormal		Severely Subnormal		Total		Grand Total
	Under 16	16+	Under 16	16+	Under 16	16+	Under 16	16+	Under 16	16+	
Awaiting admission to hospital											
(a) Urgent admission	–	–	–	–	1	1	25	6	26	7	33
(b) Non-urgent admission	–	2	–	–	1	–	21	5	22	7	29
(c) Total	–	2	–	–	2	1	46	11	48	14	62
Admitted for temporary care											
(a) To N.H.S. Hospitals	–	–	–	–	–	4	27	4	27	8	35
(b) to L.A. Accommodation	–	–	–	–	–	–	–	–	–	–	–
(c) Elsewhere	–	–	–	–	–	–	–	–	–	–	–
(d) Total	–	–	–	–	–	4	27	4	27	8	35

TABLE 4D–PATIENTS AWAITING ADMISSION TO HOSPITAL (31st DECEMBER 1967)

PATIENTS ADMITTED FOR TEMPORARY RESIDENTIAL CARE DURING 1967

Category / Age	Mentally Ill		Psycopath		Subnormal		Severely Subnormal		Total		Grand Total
	Under 16	16+	Under 16	16+	Under 16	16+	Under 16	16+	Under 16	16+	
Awaiting admission to hospital											
(a) Urgent admission	–	–	–	–	–	1	21	5	21	6	27
(b) Non-urgent admission	–	–	–	–	–	5	16	4	16	9	25
(c) Total	–	–	–	–	–	6	37	9	37	15	52
Admitted for temporary care											
(a) To N.H.S. Hospitals	–	–	–	–	–	1	27	10	27	11	38
(b) to L.A. Accommodation	–	–	–	–	–	–	–	–	–	–	–
(c) Elsewhere	–	–	–	–	–	–	–	–	–	–	–
(d) Total	–	–	–	–	–	1	27	10	27	11	38

TABLE 5 AMBULANCE SERVICE STATISTICS

TABLE A—NUMBER OF PATIENTS CARRIED AND MILEAGE INVOLVED

PATIENTS	1963	1964	1965	1966	1967
Ambulance vehicles	74,755	82,938	94,345	101,015	103,322
Hospital Car Service	35,316	38,795	45,588	39,830	42,752
MILEAGE					
Ambulance vehicles	639,276	676,701	741,872	788,419	794,529
Hospital Car Service	734,567	799,005	896,153	795,459	832,942

TABLE B—AVERAGE NUMBER OF MILES PER PATIENT

	1963	1964	1965	1966	1967
Ambulance vehicles	8.6	8.2	7.9	7.8	7.7
Hospital Car Service	20.8	20.6	19.6	20.0	19.5

TABLE C—NUMBER OF PATIENTS CONVEYED

YEAR	ILLNESS	ACCIDENTS	MATERNITY	HOSPITAL CAR REMOVALS	TOTAL CASES
1963	69,435	3,282	2,038	35,316	110,071
1964	77,524	3,395	2,019	38,795	121,733
1965	89,309	3,173	1,863	45,588	139,933
1966	95,765	3,469	1,781	39,830	140,845
1967	98,019	3,460	1,843	42,752	146,074

TABLE D–PATIENTS CONVEYED PER THOUSAND OF POPULATION

YEAR	ILLNESS	ACCIDENTS	MATERNITY	OTHER REMOVALS
1963	166.4	7.9	4.9	84.6
1964	179.2	7.8	4.7	89.7
1965	199.4	7.1	4.1	101.8
1966	208.1	7.5	3.9	86.5
1967	207.7	7.3	3.9	90.6

TABLE E–CASES TRANSPORTED AND COUNTY POPULATION

YEAR	CASES TRANSPORTED	COUNTY POPULATION
1963	110,071	417,360
1964	121,733	432,690
1965	139,933	447,950
1966	140,845	460,220
1967	146,074	471,840

TABLE F–RUNNING COSTS RELATING TO AMBULANCE VEHICLES

	AVERAGE COST PER		
YEAR	MILE RUN	JOURNEY	PATIENTS CARRIED
1962/63	3s. 4d.	55s. 7d.	30s. 8d.
1963/64	3s. 6d.	55s. 7d.	29s. 3d.
1964/65	3s. 8d.	57s. 8d.	29s. 3d.
1965/66	3s. 8d.	60s. 2d.	29s. 1d.
1966/67	4s. 2d.	68s. 11d.	32s. 6d.

TABLE SIX

SCHOOL HEALTH SERVICE

PART I 1966

MEDICAL INSPECTION OF PUPILS ATTENDING MAINTAINED PRIMARY AND SECONDARY SCHOOLS (INCLUDING NURSERY AND SPECIAL SCHOOLS)

A. PERIODIC MEDICAL INSPECTIONS 1966

Age groups Inspected (By year of Birth)	No. of Pupils Inspected	Physical Conditions of Pupils Inspected	
		Number Satisfactory	Number Unsatisfactory
(1)	(2)	(3)	(4)
1962 and later	508	506	2
1961	3,381	3,360	21
1960	3,831	3,826	5
1959	1,076	1,075	1
1958	600	599	1
1957	546	545	1
1956	2,860	2,859	1
1955	2,186	2,185	1
1954	615	613	2
1953	310	302	8
1952	963	963	–
1951 and earlier	2,908	2,908	–
TOTALS	19,784	19,741	43

B.–PUPILS FOUND TO REQUIRE TREATMENT AT PERIODIC MEDICAL INSPECTIONS 1966

Age Groups Inspected (By year of Birth)	For Defective Vision (Excluding Squint)	For any other conditions recorded in Part II A	Total Individual Pupils
1962 and later	14	82	91
1961	142	601	674
1960	189	808	892
1959	89	231	280
1958	51	112	147
1957	43	111	145
1956	244	472	636
1955	199	310	440
1954	93	95	165
1953	35	42	63
1952	122	151	254
1951 and earlier	485	392	785
TOTALS	1,706	3,407	4,572

C.–OTHER INSPECTIONS

Number of Special Inspections	733
Number of Re-Inspections	5,326
TOTAL	6,059

D.–INFESTATION WITH VERMIN

(1)	Total number of individual examinations of pupils in the schools by the school nurses or other authorised persons	56,377
(2)	Total number of individual pupils found to be infested	366
(3)	Number of individual pupils in respect of whom cleansing notices were issued (Section 54 (2), Education Act, 1944)	–
(4)	Number of individual pupils in respect of whom cleansing orders were issued (Section 54 (3), Education Act, 1944)	–

PART II 1966

DEFECTS FOUND BY MEDICAL INSPECTION DURING THE YEAR

A.–PERIODIC INSPECTIONS

Code No.	Defects or Disease	Entrants "T"	Entrants "O"	Leavers "T"	Leavers "O"	Others "T"	Others "O"	Total "T"	Total "O"
4	Skin	163	71	121	31	138	59	422	161
5	Eyes (a) Vision	482	460	572	129	652	217	1706	806
	(b) Squint	205	91	33	10	80	29	318	130
	(c) Other	38	25	12	7	35	26	85	58
6	Ears (a) Hearing	346	462	43	35	120	138	509	635
	(b) Otitis Media	154	192	14	11	39	44	207	247
	(c) Other	62	34	7	6	28	30	97	70
7	Nose and Throat	308	606	51	37	106	196	465	839
8	Speech	124	341	8	7	50	97	182	445
9	Lymphatic Glands	15	132	3	10	9	44	27	186
10	Heart	29	214	10	38	16	68	55	320
11	Lungs	150	166	14	26	50	84	214	276
12	Development (a) Hernia	31	39	1	5	17	24	49	68
	(b) Other	41	165	21	46	79	147	141	358
13	Orthopaedic (a) Posture	20	50	52	35	47	65	119	150
	(b) Feet	154	113	40	35	115	81	309	229
	(c) Other	68	105	57	30	53	79	178	214
14	Nervous System (a) Epilepsy	14	22	4	6	11	10	29	38
	(b) Other	13	53	8	15	13	30	34	98
15	Psychological (a) Development	30	107	1	5	37	87	68	199
	(b) Stability	78	377	12	23	41	193	131	593
16	Abdomen	34	65	10	9	27	34	71	108
17	Other	145	130	78	15	170	68	393	213

"T"–means requiring treatment "O"–means requiring observation

B.–SPECIAL INSPECTIONS

Defect Code No.	Defect or Disease	Requiring Treatment	Requiring Observation
4	Skin	32	14
5	Eyes (a) Vision	242	170
	(b) Squint	38	22
	(c) Other	4	5
6	Ears (a) Hearing	44	125
	(b) Otitis Media	8	24
	(c) Other	6	2
7	Nose and Throat	39	58
8	Speech	30	45
9	Lymphatic Glands	1	7
10	Heart	4	103
11	Lungs	25	45
12	Development (a) Hernia	3	7
	(b) Other	12	35
13	Orthopaedic (a) Posture	25	9
	(b) Feet	14	20
	(c) Other	14	22
14	Nervous System (a) Epilepsy	10	7
	(b) Other	4	21
15	Psychological (a) Development	5	31
	(b) Stability	24	84
16	Abdomen	6	21
17	Other	70	12

PART III 1966

TREATMENT OF PUPILS ATTENDING MAINTAINED PRIMARY AND SECONDARY SCHOOLS (INCLUDING NURSERY AND SPECIAL SCHOOLS)

A.—EYE DISEASE, DEFECTIVE VISION AND SQUINT

	Number of cases known to have been dealt with
External and other, excluding errors of refraction and squint	205
Errors of refraction (including squint)	4,002
TOTAL	4,207
Number of pupils for whom spectacles were prescribed	1,337

B.—DISEASES AND DEFECTS OF EAR, NOSE AND THROAT

	Number of cases known to have been dealt with
Received operative treatment—	
(a) for diseases of the ear	8
(b) for adenoids and chronic tonsilitis	30
(c) for other nose and throat conditions	9
Received other forms of treatment	78
TOTAL	125
Total number of pupils in schools who are known to have been provided with hearing aids—	
(a) in 1966	66
(b) in previous years	116

C.—ORTHOPAEDIC AND POSTURAL DEFECTS

	Number of cases known to have been dealt with
(a) Pupils treated at clinics or out-patients departments	659
(b) Pupils treated at school for postural defects	22
TOTAL	681

D.–DISEASES OF THE SKIN

(excluding uncleanliness, for which see Table D part 1)

		Number of cases known to have been dealt with
Ringworm–	(i) Scalp	3
	(ii) Body	9
Scabies		4
Impetigo		71
Other skin diseases		147
	TOTAL	234

E.–CHILD GUIDANCE TREATMENT

Pupils treated at Child Guidance clinics	603

F.–SPEECH THERAPY

Pupils treated by Speech Therapists	467

G.–OTHER TREATMENT GIVEN

(a)	Pupils with minor ailments	546
(b)	Pupils who received convalescent treatment under School Health Service arrangements	1
(c)	Pupils who received B.C.G. vaccination	4,552
(d)	Pupils who received re-inforcing doses:–	
	(i) Poliomyelitis	1,755
	(ii) Diphtheria	106
	(iii) Diphtheria/Tetanus	1,706
	TOTAL	8,666

PART IV 1966

DENTAL INSPECTION AND TREATMENT CARRIED OUT BY THE AUTHORITY

Attendances and Treatment	AGES 5 to 9	10 to 14	15 and over	TOTAL
First Visit	3,246	2,113	323	5,682
Subsequent visit	5,067	3,749	590	9,406
Total visits	8,313	5,862	913	15,088
Additional courses of treatment commenced	151	66	6	223
Fillings in permanent teeth	2,025	3,696	657	6,378
Fillings in deciduous teeth	3,501	318	–	3,819
Permanent teeth filled	1,810	3,358	620	5,788
Deciduous teeth filled	3,273	301	–	3,574
Permanent teeth extracted	170	548	104	822
Deciduous teeth extracted	2,378	589	–	2,967
General anaesthetics	1,148	471	40	1,659
Emergencies	60	19	5	84
Number of pupils X-rayed				210
Prophylaxis				988
Teeth otherwise conserved				556
Number of teeth root filled				8
Inlays				1
Crowns				12
Courses of treatment completed				4,112
ORTHODONTICS				
Cases remaining from previous year				70
New cases commenced during year				45
Cases completed during year				50
Cases discontinued during year				7
No. of removable appliances fitted				61
No. of fixed appliances fitted				5
Pupils referred to Hospital Consultant				16
PROSTHETICS				
Pupils supplied with F.U. or F.L. (first time)				–
Pupils supplied with other dentures (first time)				15
Number of dentures supplies				15
ANAESTHETICS				
General Anaesthetics administered by Dental Officers				–

INSPECTIONS

(a)	First inspection at school. Number of Pupils	32,347
(b)	First inspection at clinic. Number of Pupils	322
	Number of (a) and (b) found to require treatment	14,525
	Number of (a) and (b) offered treatment	12,546
(c)	Pupils re-inspected at school clinic	115
	Number of (c) found to require treatment	100

SESSIONS

Sessions devoted to treatment	2,888
Sessions devoted to Inspection	282
Sessions devoted to Dental Health Education	322

TABLE SEVEN

SCHOOL HEALTH SERVICE

PART I 1967

MEDICAL INSPECTION OF PUPILS ATTENDING MAINTAINED PRIMARY AND SECONDARY SCHOOLS (INCLUDING NURSERY AND SPECIAL SCHOOLS)

A.—PERIODIC MEDICAL INSPECTIONS 1967

Age groups Inspected (By year of Birth) (1)	No. of Pupils Inspected (2)	Physical Condition of Pupils Inspected: Number Satisfactory (3)	Physical Condition of Pupils Inspected: Number Unsatisfactory (4)
1963 and later	755	750	5
1962	3,705	3,695	10
1961	4,192	4,178	14
1960	1,424	1,417	7
1959	730	728	2
1958	618	615	3
1957	3,237	3,228	9
1956	2,418	2,415	3
1955	758	757	1
1954	455	453	2
1953	1,537	1,533	4
1952 and earlier	4,187	4,165	22
TOTALS	24,016	23,934	82

B.–PUPILS FOUND TO REQUIRE TREATMENT AT PERIODIC MEDICAL INSPECTIONS 1967

Age Groups Inspected (By year of Birth)	For Defective Vision (Excluding Squint)	For any other conditions recorded in Part II A	Total Individual Pupils
1963 and later	25	159	163
1962	165	729	816
1961	222	944	1,070
1960	92	283	352
1959	58	165	214
1958	60	136	185
1957	320	597	832
1956	253	440	648
1955	119	129	239
1954	68	83	134
1953	192	220	368
1952 and earlier	582	529	974
TOTALS	2,156	4,414	5,995

C.–OTHER INSPECTIONS 1967

Number of Special Inspections	849
Number of Re-Inspections	6,085
TOTAL	6,934

D.–INFESTATION WITH VERMIN 1967

(1)	Total number of individual examinations of pupils in the schools by the School Nurses or other authorised persons	48,319
(2)	Total number of individual pupils found to be infested	280
(3)	Number of individual pupils in respect of whom cleansing notices were issued (Section 54 (2), Education Act, 1944)	–
(4)	Number of individual pupils in respect of whom cleansing orders were issued (Section 54 (3), Education Act, 1944)	–

PART II

DEFECTS FOUND BY MEDICAL INSPECTION DURING THE YEAR

A.—PERIODIC INSPECTIONS 1967

Code No.	Defect or Disease	Entrants		Leavers		Others		Total	
		"T"	"O"	"T"	"O"	"T"	"O"	"T"	"O"
4	Skin	222	141	228	111	255	95	705	347
5	Eyes (a) Vision	539	534	750	221	867	243	2,156	998
	(b) Squint	257	104	31	13	108	29	396	146
	(c) Other	44	40	14	7	47	31	105	78
6	Ears (a) Hearing	402	487	40	72	145	209	587	768
	(b) Otitis Media	100	215	17	15	34	48	151	278
	(c) Other	22	47	13	27	25	25	60	99
7	Nose and Throat	350	874	81	77	148	239	579	1,190
8	Speech	187	469	4	15	79	80	270	564
9	Lymphatic Glands	10	241	2	9	8	44	20	294
10	Heart	27	263	8	78	12	96	47	437
11	Lungs	161	252	26	43	88	108	275	403
12	Development (a) Hernia	36	52	–	2	17	32	53	86
	(b) Other	90	236	52	72	144	137	286	445
13	Orthopaedic (a) Posture	8	38	20	54	31	72	59	164
	(b) Feet	180	242	51	79	114	121	345	442
	(c) Other	68	122	50	74	61	99	179	295
14	Nervous System								
	(a) Epilepsy	17	21	16	7	14	9	47	37
	(b) Other	14	58	17	16	29	43	60	117
15	Psychological								
	(a) Development	24	145	3	14	37	92	64	251
	(b) Stability	150	495	31	60	87	253	268	808
16	Abdomen	56	92	9	20	30	69	95	181
17	Other	226	157	170	51	260	84	656	292

"T"—means requiring treatment "O"—means requiring observation

B.–SPECIAL INSPECTIONS 1967

Defect Code No.	Defects or Disease	Requiring Treatment	Requiring Observation
4	Skin	61	20
5	Eyes (a) Vision	307	139
	(b) Squint	63	19
	(c) Other	8	6
6	Ears (a) Hearing	51	189
	(b) Otitis Media	15	36
	(c) Other	4	8
7	Nose and Throat	87	135
8	Speech	63	81
9	Lymphatic Glands	3	17
10	Heart	7	97
11	Lungs	46	63
12	Development (a) Hernia	9	10
	(b) Other	42	48
13	Orthopaedic (a) Posture	18	10
	(b) Feet	40	32
	(c) Other	22	30
14	Nervous System (a) Epilepsy	10	5
	(b) Other	14	25
15	Psychological (a) Development	43	75
	(b) Stability	89	135
16	Abdomen	9	22
17	Other	58	22

PART III

TREATMENT OF PUPILS ATTENDING MAINTAINED PRIMARY AND SECONDARY SCHOOLS (INCLUDING NURSERY AND SPECIAL SCHOOLS)

A.–EYE DISEASE, DEFECTIVE VISION AND SQUINT 1967

	Number of cases known to have been dealt with
External and Other, excluding errors of refraction and squint	233
Errors of Refraction (including squint)	4,392
TOTAL	4,625
Number of Pupils for whom spectacles were prescribed	1,445

B.–DISEASES AND DEFECTS OF EAR, NOSE AND THROAT

	Number of cases known to have been dealt with
Received operative treatment–	
(a) for diseases of the ear	2
(b) for adenoids and chronic tonsilitis	21
(c) for other nose and throat conditions	1
Received other forms of treatment	4
TOTAL	28
Total number of pupils in schools who are known to have been provided with hearing aids–	
(a) in 1967	40
(b) in previous years	122

C.–ORTHOPAEDIC AND POSTURAL DEFECTS

	Number of cases known to have been dealt with
(a) Pupils treated at clinics or out-patients departments	663
(b) Pupils treated at school for postural defects	–
TOTAL	663

D.–DISEASES OF THE SKIN

(excluding uncleanliness, for which see Table D part I)

	Number of cases known to have been dealt with
Ringworm (i) Scalp	4
(ii) Body	8
Scabies	23
Impetigo	39
Other skin diseases	45
TOTAL	119

E.–CHILD GUIDANCE TREATMENT

Pupils treated at Child Guidance clinics	560

F.–SPEECH THERAPY

Pupils treated by Speech Therapists	474

G.–OTHER TREATMENT GIVEN

(a)	Pupils with minor ailments	559
(b)	Pupils who received convalescent treatment under School Health Service arrangements	–
(c)	Pupils who received B.C.G. vaccination	4,685
(d)	Pupils who received re-inforcing doses:–	
	(i) Poliomyelitis	2,944
	(ii) Diphtheria	168
	(iii) Diphtheria/Tetanus	3,271
	TOTAL	11,627

ANAESTHETICS

General Anaesthetics administered by Dental Officers	–	–	–	–

INSPECTIONS

(a)	First inspection at school. Number of Pupils	37,275
(b)	First inspection at clinic. Number of Pupils	434
	Number of (a) and (b) found to require treatment	13,791
	Number of (a) and (b) offered treatment	10,408
(c)	Pupils re-inspected at School Clinic	213
	Number of (c) found to require treatment	187

SESSIONS

Sessions devoted to treatment	2,965
Sessions devoted to Inspection	325
Sessions devoted to Dental Health Education	426

PART IV 1967

DENTAL INSPECTION AND TREATMENT CARRIED OUT BY THE AUTHORITY

Attendances and Treatment	AGES 5 to 9	10 to 14	15 and over	Total
First visit	3,062	2,013	255	5,330
Subsequent visit	5,041	4,149	519	9,709
Total visits	8,103	6,162	774	15,039
Additional courses of–				
Treatment commenced	59	52	2	113
Fillings in permanent teeth	2,270	3,838	584	6,692
Fillings in deciduous teeth	3,725	336	–	4,061
Permanent teeth filled	1,907	3,415	539	5,861
Deciduous teeth filled	3,492	320	–	3,812
Permanent teeth extracted	108	601	86	795
Deciduous teeth extracted	1,708	608	–	2,316
General anaesthetics	791	400	20	1,211
Emergencies	83	24	6	113
Number of pupils X-rayed				258
Prophylaxis				746
Teeth otherwise conserved				497
Number of teeth root filled				21
Inlays				5
Crowns				16
Courses of treatment completed				4,455
ORTHODONTICS				
Cases remaining from previous year				58
New cases commenced during year				102
Cases completed during year				95
Cases discontinued during year				10
No. of removable appliances fitted				100
No. of fixed appliances fitted				2
Pupils referred to Hospital Consultant				32
Pupils supplied with F.U. or F.L. (first time)	–	–	–	–
Pupils supplied with other dentures (first time)	–	8	10	18
Number of dentures supplied	–	8	10	18

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